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Medical Knowledge and Medical Power: Control of Women's Bodies in Seventeenth-Century England

by

Lisa Wynne Smith ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Arts in History

Department of History and Classics

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Abstract

One of the ways in which historians of women can determine the status of women within a society is to study the extent to which women retained control over their bodies. The purpose of this study is to examine whether or not a misogynistic medical theory affected the reality of women's health care in seventeenth-century England. During the early modern period, ideas about the inferiority and passivity of women became increasingly entrenched within academia and politics. Despite the use of medical theories to bolster patriarchal ideas, medical theories did not directly affect women's daily lives. Early modern English women had their own understanding of their bodies, had an extensive knowledge of the practice of medicine, and possessed significant power within the patient-practitioner relationship. In controlling their own health care, seventeenth-century women in England maintained authority over their own bodies and women's health matters.

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Table of Contents

Introduction 1

Chapter One 11
“A worlde of yt selfe”: The Understanding of Women’s Bodies in the Seventeenth Century 11

Chapter Two 40
The Expertise of Women: Women and Medical Knowledge 40

Chapter Three 65
Active ‘Patients’: Women’s Sick Roles and Gendered Treatment . . 65

Conclusion 98

Bibliography 103

Introduction

> Sith the preseruation and care of the family touching their health and soundnesse of body, consistreth most in diligence: it is meet that shee ["euery Hous-wife"] haue a phisicall kinde of knowledge, how to administer many wholsome receits or medicines for the good of their healthes as well as to preuent the first occasion of sicknesse, as to take away the effects and euill of the same when it hath made seazure on the body.[1]

As Gervase Markham wrote, a knowledge of medicine and healing was considered not only appropriate, but necessary, for seventeenth-century English women. Markham's book was only one of many advice books for women that included a large section on household medicine. After the invention of the printing press, the proliferation of English medical treatises and medical commonplace books provided medical knowledge to a broad, non-scholarly, audience.[2] During the seventeenth century, however, a shift in scholarly medicine was occurring. Not only did scholastic medical theories become increasingly misogynistic, but medical practitioners began to professionalise. One of the groups especially targeted in the criticisms of the 'professionals' were the allegedly ignorant female practitioners.[3] Such changes, which decentralised female viewpoints, had the potential to radically affect medical treatment for women in English society. Did the encroachment of a male-predominated profession and a misogynistic medical theory affect the health care received by women?

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[1] Gervase Markham, Countrey Contentments, or the English Huswife (London: R. B. for R. Jackson, 1623), 4.

[2] See Katharine Park, "Medicine and society in medieval Europe, 500-1500", 59-90 in Medicine in Society: Historical Essays ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 81; Mary E. Fissell, "Readers, texts and contexts: vernacular medical works in early modern England", 72-97 in The Popularization of Medicine 1650-1850 ed. Roy Porter (London and New York: Routledge, 1992); Paul Slack, "Mirrors of Health and Treasures of Poor Men: the Uses of the Vernacular Medical Literature of Tudor England", 237-274 in Health, Medicine and Mortality in the Sixteenth Century ed. Charles Webster (Cambridge: Cambridge University Press, 1979).

[3] Cf. Thomas Benedek, "The Changing Relationship Between Midwives and Physicians during the Renaissance", Bulletin of the History of Medicine 51 (1977): 550-564; Anne Gardiner, "Elizabeth Cellier in 1688 on Envious Doctors and Heroic Midwives Ancient and Modern", Eighteenth-Century Life 14 (1990): 24-34; Alison Klairmont Lingo, "Empirics and Charlatans in Early Modern France: The Genesis of the Classification of the 'Other' in Medical Practice", Journal of Social History 19 (1985-6): 583-603; Lynne Tatlock, "Speculum Feminarum: Gendered Perspectives on Obstetrics and Gynecology in Early Modern Germany", Signs: Journal of Women in Culture and Society 17 (1992): 725-760.

Although the assumption that the misogyny of theory directly translated into practice would be easy to make, the medical treatment of women in seventeenth-century England was far more complex than historians have considered. In the historiography of this subject, there has been a tendency to concentrate on the perceptions of 'elite' males, resulting in an unbalanced view of 'women's nature'. For example, while male medical practitioners established theories about women's bodies, women had their own concepts about the female body which did not always agree with the 'theories'. Likewise, the transmission of ideas between elite, popular, and women's culture was much more fluid than often thought. Another tendency of historians has been to see women as passive victims in medicine. However, many early modern women had a broadly based medical knowledge which rivalled that of professional practitioners. Even when women became patients, they retained a great deal of control over the medical treatments that they received. Thus, historians have overlooked the implications that women could undermine the patriarchal theories even as they bolstered the ideas. Since the late 1970s, however, the fields of the history of medicine and the history of women have undergone rapid expansion. Historians have examined subjects such as the impact of professionalisation on medicine, scientific and medical perceptions about women, and female practitioners. By considering different aspects of health, illness, medical practice, and the meaning of healing in society, a number of excellent studies have added significantly to the histories of medicine and women. For example, during the last decade, medical history has begun to emphasise the patient/practitioner relationship and the experience of suffering.[4] This area has thus far proved to be most informative in regards to the social meanings of sickness and healing. Nonetheless, there is a paucity of research about early modern women's understanding of their bodies and of their own health care, and about the relationship between female patients and medical practitioners.[5] Indeed, despite the importance of earlier research, there are a number of methodological flaws in the common approaches used to study the history of women and medicine.

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[4] For the early modern period, see especially Dorothy Porter and Roy Porter, Patient's Progress: Doctors and Doctoring in Eighteenth-century England (Oxford: Polity Press, 1989); Lucinda McCray Beier, Sufferers and Healers: The Experience of Illness in Seventeenth-Century England (London: Routledge & Kegan Paul, 1987).

Relying solely on academic medical writings for women's history is methodologically dangerous since such writings reveal only the image of women as seen by male academics. One of the first approaches to the history of women and medicine was that of analysing the philosophical and scientific perceptions of women.[6] Ian Maclean has examined the transmission of common ideas about women, which were often expressed in the same image or wording between academic disciplines. He concludes that during the Renaissance there was a shift in medical theories from the hegemony of Galen to Aristotle, firmly entrenching misogynistic ideas within academia.[7] Other historians, such as Thomas Laqueur, have also studied these academic ideas. While Maclean clearly emphasises that his study concerns only scholastic ideas about women, Laqueur has taken the academic ideas about women to be more representative of society's views. In Making Sex, Laqueur suggests that there was a one-sex portrayal of the human body, in which females were inverted males, from Antiquity to the Renaissance; by the nineteenth century, this concept was supplanted by the modern two-sex model. He argues that this understanding of the body and of sexuality influenced the course and results of scientific research.[8] There is a serious flaw in this argument since Laqueur traces an essentially scholastic idea throughout time and assumes that this idea influenced the broader society. He neglects to examine either the implications or the impact of the scientific theory (one-sex and two-sex models) on popular culture.[9] Although other historians have similarly emphasised academic perceptions of women in order to understand women's health care,[10] concentration on the scholastic perceptions about women omits a far richer consideration of what women themselves understood.

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[5] For the seventeenth and eighteenth centuries, see Porter and Porter, and Beier who each have a chapter on women patients and Barbara Duden's, The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany trans. Thomas Dunlap (Cambridge, Mass.: Harvard University Press, 1991). More attention has been given to the experience of female patients for the nineteenth century. C.f. Barbara Ehrenreich and Deirdre English, For Her Own Good: 150 Years of the Experts' Advice to Women (London: Pluto Press, 1979); Mark S. Micale, "Hysteria and Its Historiography: A Review of Past and Present Writings (I and II)", History of Science 27 (1989), 223-261 and 319-357; Janet Oppenheim, "Shattered Nerves": Doctors, Patients, and Depression in Victorian England (New York and Oxford: Oxford University Press, 1991).

[6] See Ian MacLean, The Renaissance Notion of Woman: A Study in the Fortunes of Scholasticism and Medical Science in European Intellectual Life (Cambridge: Cambridge University Press, 1980).

[7] Ibid.

[8] Thomas Laqueur, Making Sex (Cambridge, Mass.: Harvard University Press, 1990), p. 16.

Several historians have written on the decline of midwifery, or conversely, the rise of professionalised medicine, and its results for women's medical treatment during the early modern period. Implicit in this approach is the assumption that the health care received by women depended on the gender of the medical practitioner. On the one hand, Edward Shorter has claimed that the decline in midwifery was positive for women because the health care provided by more 'knowledgeable' male practitioners was superior.[11] In contrast, Barbara Ehrenreich and Deirdre English have suggested that scientific progress, instead of improving women's lives, was used to emphasise women's passivity, weakness, and dependence.[12] Other feminist scholars, like Mary Chamberlain, have argued that the rise of professionalised medicine resulted in a less female-centred health care.[13] Despite their differences, all of these authors assume a close parallel between the gender of the practitioners, which would have determined their medical training and knowledge, and the actual practice of medicine. Likewise, they do not examine the extent to which the treatments by male and female practitioners differed or remained the same. For example,

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[9] In Chapter 3, Laqueur deals with the legal ramifications of the one-sex idea in relation to determining the gender of hermaphrodites and homosexuals. However, he does not acknowledge that the legal courts were also 'elite' culture and that the testimonies of witnesses would have been influenced by those asking questions and filtered through the perceptions of those recording the answers.

[10] Cf. Gianna Pomata critiques the sections on medicine in Histoire des femmes en Occident t.II Le Moyen Age ed. Christiane Klapisch-Zuber (Paris: Plon, 1991) and t.III Le XVIe-XVIIIe siècle eds. Natalie Zemon Davis and Arlette Farge (Paris: Plon, 1991) in her "Histoire des Femmes et 'Gender History'", 1019-1026 Annales ESC 48 (1993), 1022.

[11] Edward Shorter, A History of Women's Bodies (London: Allen Lane, 1983); Mireille Laget has made similar suggestions in her "La Naissance aux Siècles Classiques: Pratique des accouchements et attitudes collectives en France aux XVIIe et XVIIIe siècles", Annales ESC 2, 32 (1977), 958-992.

[12] Cf. Ehrenreich and English, For Her Own Good.

[13] Cf. Mary Chamberlain, Old Wives' Tales: their History, Remedies and Spells (London: Virago Press, 1981), "Conclusions"; or Hilda Smith, "Gynecology and Ideology in Seventeenth-Century England", 97-114 in Liberating Women's History, ed. B.A. Carroll (Urbana: University of Illinois Press, 1976); Caroline Merchant advances a similar line of argument on the rise of mechanism and the subsequent attempts to control nature, and women, through science in her Death of Nature: Women, Ecology and the Scientific Revolution (San Francisco: Harper & Row Publishers, 1980).

Hilda Smith discusses the 'brutal' treatments of women by male practitioners, such as cupping near the genitals, while Chamberlain writes of "The Inhuman Face of Medicine" and "Medicine as Intervention".[14] Both Smith and Chamberlain depict the treatments provided by male practitioners as being hostile to female patients. In turn, Shorter emphasises the interventionist nature of midwives, which, he argues, resulted from their medical ignorance.[15] Failing to compare the medical theories and the reality of medical practice, and assuming that the treatment was gendered, are serious oversights.

The third, and most used, approach for the history of women as patients is the study of women's sexuality and reproductive roles. This broad field encompasses the vast majority of the medical history of women, dealing with pregnancy, childbirth, perceptions of the female body, and breastfeeding.[16] Several problems arise from concentrating primarily on women's reproduction and sexuality. First of all, this concentration has never been explicitly justified. By emphasising women as reproductive and sexual beings, historians reduce women to the mere sum of their parts, thus doing the history of women, and medicine, a potential disservice. As Barbara Duden's Woman Beneath the Skin and Elborg Forster's article on Liselotte von der Pfalz show, there are many other aspects of women's health care, such as perceptions of their bodies or attitudes toward health and illness, yet to be explored.[17] In addition, there has been a tendency to portray women as passive victims, rather than active agents, in their health care.[18] In contrast, Roy and Dorothy Porter and Lucinda Beier assert that the health care of women was governed largely by finances and the patients' selection of the practitioners.[19] Adrian Wilson and

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[14] Smith, "Gynecology and Ideology", 102; Chamberlain, Old Wives, 145-153.

[15] Shorter, Women's Bodies, 35-47.

[16] Cf. Valerie Fildes, ed., Women as Mothers in Pre-industrial England (London: Routledge, 1990) has articles on the experiences of maternity and pregnancy and the ceremony of childbirth; P. Crawford, "Menstruation in Seventeenth-Century England", Past & Present 91 (1981), 47-73; Smith, "Gynecology and Ideology"; Valerie Fildes, Breast, Bottles and Babies (Edinburgh: Edinburgh Press, 1986).

[17] Duden, Woman Beneath; Elborg Forster, "From the Patient's Point of View: Illness and Health in the Letters of Liselotte von der Pfalz (1652-1722)", Bulletin of the History of Medicine 60 (1986), 297-320.

[18] Cf. Crawford, "Menstruation"; Smith, "Gynecology and Ideology"; Eccles, Obstetrics and Gynecology; Shorter, Women's Bodies.

[19] Beier, Sufferers and Healers; Porter and Porter, Patient's Progress.

Linda Pollock have further shown how women could be 'active agents' in their own health. In his analysis of seventeenth-century childbirth rituals, Wilson perceives a 'collective culture of women' in which women could temporarily usurp masculine authority within the home.[20] Likewise, Pollock discusses how women could manipulate the popular concept of frequent miscarriage and the delicacy of women during pregnancy. She suggests that many 'miscarriages' in the seventeenth century were really abortions.[21] Although the emphasis on the historical study of women's reproductive/sexual roles as significant to women's health care may be important, the concentration on this area has never been justified; further investigation is needed to determine what other aspects of women's health care have been neglected, or that more research into women's reproductive/sexual roles is warranted.

As Roy and Dorothy Porter, Lucinda McCray Beier and Barbara Duden have demonstrated, a much fuller picture of medical treatment emerges when factors such as the correlation between theory and reality, a comparison of treatments according to gender, and the patient/practitioner relationship, are considered.[22] In Patient's Progress, Roy and Dororthy Porter study the medical 'consumer' of ca. 1650-1850 in England. They depict the patient as having a great deal of power both in selecting practitioners and in dictating the types of treatment that practitioners provided.[23] Although their study primarily deals with the eighteenth century, the findings of Beier support such a trend for the seventeenth century.[24] In addition to looking at the relationship between patients and practitioners, she examines the treatments provided, finding that many of the treatments were not necessarily those promoted by academic medicine. In fact, the medical services provided by amateur female practitioners routinely matched those of the professionals.[25] Duden's study of the medical cases discussed in the eight volume Diseases of Women written by Johann Storch, an early eighteenth-century physician, also discusses the 'power of the patient' and the self-treatments of women. The most interesting aspect to Duden's discussion is about the tensions that Storch experienced between providing medical treatment according to theory or according to what his patients desired; most frequently, he gave the treatment that the patient wanted.[26] Porter and Porter refer to the patients' desires for an often brutal treatment; the more dramatic the treatment, the more efficacious it must be.[27] Such findings call into question the appropriateness of assuming, without proof, gendered differences between medical treatments and assuming no difference between practice and theory.

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[20] Adrian Wilson, "The Ceremony of Childbirth and its Interpretation", 68-107 in Women as Mothers in Pre-Industrial England ed. Valerie Fildes (London and New York: Routledge, 1990).
[21] Linda A. Pollock, "Embarking on a Rough Passage: the Experience of Pregnancy in Early-Modern Society", pp. 39-67 in Women as Mothers in Pre-Industrial England ed. Valerie Fildes.
[22] Porter and Porter, Patient's Progress; Beier, Sufferers and Healers; Duden, Woman Beneath.
[23] Porter and Porter, Patient's Progress.
[24] Beier, Sufferers and Healers.
[25] Ibid., 217.

Despite the many methodologies for the subject of women and medicine, the question of whether or not misogynistic medical theories and an increasingly male-dominated medical practice affected women's health care in seventeenth century England has often been omitted. By finding 'new' sources, historians of women and medicine could open different lines of inquiry or re-examine old evidence. There are a number of sources that have been overlooked in the study of medicine and which present exciting opportunities for historians to explore what women knew and thought about medicine. For example, Beier and Duden show how medical practitioners' casebooks can be studied. Beier has looked at them to see the different types of treatments that the practitioners provided, for clues as to the patient-practitioner relationship, and for the types of problems treated.[28] Duden's use of Storch's case studies about women is innovative. She has examined how the women's stories in their own words and thoughts emerge through Storch's writings. In his books, Storch also included the letters written to him by female patients; the letters further reveal how women perceived illness and health.[29] Historians such as Porter and Porter and Beier have revealed the necessity for examining sources such as letters and diaries to understand what the patient thought. Beier, however, is the only one who has attempted an analysis of women's diaries to determine the health care that they received and how they understood their illnesses.[30] Although Pollock examined a few family recipe collections for information about remedies, cookbooks and domestic guides have been ignored as sources for medical history.[31] Published domestic guides present a plethora of information, not only revealing what information was readily available to women and their households, but reflecting the medical knowledge of the oral culture. All of these sources provide opportunities to ascertain how medical theories and medical realities matched or diverged.

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[26] Duden, Woman Beneath, especially Chapters 3 and 4.
[27] Porter and Porter, Patient's Progress, 46-51, 60-62.
[28] Beier, Sufferers and Healers.
[29] Duden, Woman Beneath.

To understand the medical realities, the historian must first understand how the human body, specifically female body, was perceived, by scholarly medicine, society and women. In Chapter One, I examine the ideas about women's bodies held by scholars, popular culture and, more specifically, women. In early modern culture, the female body was a place of mysterious transformations which discomforted people. As Maclean has shown, medical theory had become uncompromisingly anti-female by the seventeenth century.[32] In formal medicine, women were weak, inferior and passive beings compared to males. Popular culture, in contrast, attributed the female body with magical powers, albeit in a generally negative manner. Yet for women, the female body was something altogether different. Women interpreted menstruation and pregnancy differently than did formal medicine; in some cases, women utilised the stereotypes about the female body to their advantage. Clear parallels existed between scholarly, popular and women's understanding of the female body; this understanding was far more fluid than is often recognised. The knowledge of society, practitioners, and women overlapped and diverged at various points; it is important to find at which points this occurred. Although practitioners and scholars may have been immersed in misogynistic views of women, they were also members of a society in which such views were not so distinct. As Duden demonstrated in her study of the physician Johann Storch, Storch often sought to reconcile his medical training with the reality of treating his female patients who had a different understanding of their bodies.[33] While the culture of early modern England, both scholarly and 'popular', assumed female inferiority, the increasing misogyny of formal medicine supported the ongoing political and economic changes which disadvantaged women. Nonetheless, such patriarchal views about women's bodies were both moderated and undermined in the realities of daily life.

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[30] Porters, Patient's Progress; Beier, Sufferers and Healers.
[31] Pollock, "Rough Passage".
[32] MacLean, Renaissance Notion.

In Chapter Two, I discuss one way in which the assumptions of female inferiority and weakness became moderated, especially in relation to women's health care. The cultural understanding that, within the domestic realm, women should know about medical treatments and practice, ensured that women were able to care medically for themselves and their families; women were expected to be the providers of health care for themselves, family, and neighbours. Furthermore, women were considered 'experts' in this field. Physicians and surgeons regularly exchanged medical information and recipes with amateur female practitioners. The transmission and sharing of medical knowledge forms a repeated sub-text in the letters written by women. During the seventeenth century, medical knowledge also began to be diffused through the medium of publication. This served a dual purpose. On the one hand, domestic guides, herbals and almanacs, which were frequently printed and readily available, demonstrate the increasing availability of medical knowledge. Domestic guides, with their heavy medical composition, were especially intended for a female audience. Although the segment of literate society, especially literate women, was small, information could be passed orally between a reader and an illiterate person. At the same time, such books, in contrast to more formal medical treatises, reflected the traditional medical knowledge that had previously only been transmitted orally. Moreover, the treatments suggested in the domestic guides were similar to those recommended by medical practitioners; the domestic guides and the practitioners had the same types of ingredients in the medical recipes and similar methods of treatment. In practice, medical knowledge was, to a large extent, parallel between the various types of practitioners. Early modern women had access to extensive medical knowledge, both oral and written, which frequently matched or surpassed that of 'accredited' medical practitioners.

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[33] Duden, Woman Beneath, Chapters 3 and 4.

Finally, in Chapter Three, I examine how women seeking medical assistance had ample opportunity to determine their own treatment. If women did not like or agree with the medical treatment they were receiving, they could, and often did, call in different practitioners. The 'sick role' itself was a powerful position for a woman. An ill woman determined at what point she became sick enough to be a patient. As patient, a woman was entitled to special treatment from her family and friends. Sickness could be a social event and an opportunity to withdraw from the demands of life, thus giving women some control over her own body and life. The control that a woman could attain over her body through the sick role is especially important in relation to childbirth; during the lying-in, women adopted the most powerful social role available to them. In order to determine, however, whether or not medical treatments themselves were gendered, points of comparison appear in the female-specific disease of hysteria and the male-specific disease of syphilis. Early modern society attributed moral meanings to both hysteria and syphilis. In fact, women do not seem to have been disadvantaged through the types of treatment that they received; if anything, since men were more prone to receiving surgery, men received harsher medical treatment. As active patients, women maintained control over their own health care.

Although misogynistic medical theories may have become firmly entrenched within the scholarly community, there appears to have been a sharp disjunction between medical theory and the reality of medical practice. In reality, women maintained control over several areas of their own health care: women had their own understanding of the female body, were often considered medical 'experts' within the home, actively selected their own practitioners and treatments, and could utilise the 'sick role' to their benefit. Although misogyny had been established in medical theory, it was not the reality of women's health care in seventeenth-century England.

Chapter One

"A worlde of yt selfe": The Understanding of Women's Bodies in the Seventeenth Century

In his treatise on diseases of the womb, the astrologer and medical practitioner Simon Forman (1552-1611) described the womb as "a worlde of yt selfe."[1] By the standards of early modern medicine and common medical beliefs, such a statement could just as easily apply to the female body. The female body fascinated seventeenth-century people. Since the female reproductive organs were interior, no one really knew how the female body 'worked'. Although the female genitals were assumed to be imperfect inversions of the male genitals, they retained a special power to bleed and to create life. Within the interior of the female body, the processes by which life was created and menstruation occurred were unknown. Not only was the female body considered mysterious within the early modern culture, but the female body and its workings were a perpetual source of debate for the scholars. Despite the variety of academic arguments which occurred about the 'nature of woman', the debates were founded on one assumption--that women were inferior to men. Although it has been argued that scholarly medical theories reinforced the patriarchal ideology of the ruling elite, the extent to which practitioners implemented and women understood such ideas has not been explored.[2] Through a comparison of the ideas held by scholars and women, a fluidity between the ideas of scholars and popular culture, and the modification of such ideas within society emerges. Women simultaneously adopted and adapted the 'misogyny' of the scholars' opinions.

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[1] Reprinted in Barbara Traister's "'Matrix and the Pain Therof': A Sixteenth-Century Gynaecological Essay", 436-451 in Medical History 35 (1991), 442.

[2] Cf. Patricia Crawford, "The Construction and Experience of Maternity in Seventeenth-Century England", 3-38 in Women as Mothers in Pre-Industrial England ed. V. Fildes (London and N.Y.: Routledge, 1990); Idem., "Menstruation"; Idem., "Sexual Knowledge in England, 1500-1750", 82-106 in Sexual Knowledge, Sexual Science eds. Roy Porter and Mikulas Teich (Cambridge: Cambridge University Press, 1994); Robert Martensen, "The Transformation of Eve: Women's Bodies, Medicine and Culture in Early Modern England", 107-133 in Sexual Knowledge, eds. Porter and Teich; Merchant, Death of Nature; Smith, "Gynecology and Ideology".

Before one compares scholarly and popular ideas about the female body, it is necessary to understand the medical 'setting', or the broad basis of medical beliefs. Early modern people explained illness in two ways, as God's chastisement for a moral failing or an imbalance of the 'humours'. Although illness was recognised as a physical problem, many early modern people considered the ultimate cause of disease to be spiritual. Lucinda Beier arbitrarily divides the main approaches to illness into secular and religious, noting that although medical behaviour depended on one's spiritual orientation, the approaches did not operate in opposition. The greatest difference was whether the patient favoured the cure of prayer and faith, or actively fought against the illness.[3] Several seventeenth-century diarists, to varying degrees, expressed their belief that they had erred morally and that God was chastising them for their lapse. At the same time, God provided medicinal substances and skilled healers to cure the disease.[4] Mary Rich, the Countess of Warwick, remembered how she had begun to lapse in her religious devotion when she was about 21, "at last, it pleased God to send a sudden sickness upon my only son."[5] "By earnest prayer [she] begged of Him to restore [her] child and did then solemnly promise to God . . . [she] would become a new creature", for which she was rewarded by her son's return to health.[6] Although illness was not always visited upon the offender, the offender was expected to realise the meaning behind the illness--chastisement. Despite the acknowledgement of God as both the final cause and cure of disease, religious conviction did not primarily determine medical behaviour.[7] Aiding the cure through treatment was far more practical than mere prayer, ensuring that the sick person covered all eventualities. Disease manifested God's will, but human free will decided what precautions and measures were to be taken.[8]

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[3] Beier, Sufferers and Healers, 154.
[4] Ibid., 154.
[5] T. Crofton Croker, ed. Autobiography of Mary, Countess of Warwick (London: Printed for the Percy Society, 1848), 18.
[6] Ibid., 18.
[7] Beier, Sufferers and Healers, 239.
[8] Allan Chapman discussed the relation between God's will, celestial influence and disease in "Astrological Medicine", 275-300 in Health, Medicine and Mortality in the Sixteenth Century ed. Charles Webster (Cambridge: Cambridge University Press, 1979), 286; Roy and Dorothy Porter, Patient's Progress, 7.

The theory of humours, derived from classical medicine, formed the basis of early modern medicine, both learned and popular. According to the humoral theory, everything was composed of the four elements (earth, air, fire, and water) which possessed coldness, heat, dryness, and moistness in varying degrees. Within the human body, the four humours of blood, bile or choler, black bile or melancholy, and phlegm, possessed these qualities of temperature and dryness. These in turn determined an individual's complexion to be sanguine, choleric, melancholy, or phlegmatic. Illness resulted when one's natural balance of humours became unbalanced. To effect a cure, the humoral balance needed to be restored, which was done according to the principle of opposites.[9] The humours could be upset for several reasons, the most common being a surfeit of an activity or food, catching cold, or over-heating.[10] In real terms, the humoral theory translated into the body needing to be in a 'soluble' state. Bodily evacuation was considered most beneficial to one's health, whether through menstruation or bowel movements. For example, in the autumn of 1663, Samuel Pepys suffered from wind, colic, and costiveness; it seemed especially dangerous to him that he could not break wind or have bowel movements.[11] Natural vomiting or diarrhea, sweating, expulsion of phlegm, or bleeding (through the nose, as piles, or menses) seemed to be the body's way of curing itself. Consequently, the majority of medications were purgatives, clysters, or laxatives, and the bleeding of patients was ever popular.[12] Humoral theory determined what medical treatments patients and practitioners considered to be effective.

Scholarly medicine underwent rapid change during the seventeenth-century. During this period, a scholarly community existed throughout Europe, ensuring that scholarly influences and debates passed across borders and between academic disciplines.[13] New ideas and arguments developed in early modern medicine, even though Aristotle and Galen continued to hold power as medical authorities. The old authorities often became the foundation for new ideas. For example, Theodore Brown discusses how William Harvey's vision of the circulation of blood had its precedents in an orthodox Galenic context. Indeed, Brown further argues that in later years Harvey increasingly relied on Aristotle to go beyond Galen, using Aristotelian metaphors, methods of observation, and physiological conceptions.[14] In England, the locus of scholarly medicine was Oxford; during the 1650s and 1660s, the number of Oxford physicians and the scope of their scientific interests increased rapidly.[15] Several contradictory influences and ideas about medicine and natural philosophy abounded at seventeenth-century Oxford. Although Aristotle and Galen were authorities, they were not the only source of study. Evidence from the casebook of John Locke reveals that while an undergraduate he concentrated on recent medical authors, ranging from J.B. van Helmont to Francis Glisson.[16] The richness of the growing body of medical knowledge and the openness to new ideas and arguments is especially indicated by the types of academic disputations. Prior to 1640, the disputations given in the Oxford medical faculty had been basic, practical and uniform, based on prescribed texts. In contrast, the disputations between 1651 and 1660 show the rapid spread of new ideas. Many students argued over the new authorities, such as Harvey, van Helmont, and Descartes. Although traditional topics continued to be argued, the majority of subjects were derived from the new physiology.[17] In many aspects, seventeenth century medicine was undergoing rapid change. It was within this ever-changing setting of diverse opinions that the perpetual debate about women and women's nature continued to evolve. The ongoing debates regarding women's nature and physiology further relegated women into a passive and inferior role--at least in the scholarly theories.

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[9] Audrey Eccles, Obstetrics and Gynaecology in Tudor and Stuart England (Kent, Ohio: Kent State University Press, 1982), 18; Vivian Nutton, "Medicine in the Greek World, 800-50 BC", 11-38 in The Western Medical Tradition 800 BC - AD 1800 eds. Lawrence Conrad et al. (Cambridge: Cambridge University Press, 1995), 24-25.

[10] Beier, Sufferers and Healers, 238.

[11] Ibid., 142.

[12] Ibid., 142.

[13] Maclean has discussed the flow of ideas about women between both scholarly disciplines and between scholars of different countries in Renaissance Notion.

During the Middle Ages, medicine, like all scholarly disciplines, had almost unquestioningly accepted the teachings of Aristotle as the basis of its debates and further studies. However, by the fifteenth century, many of Aristotle's tenets on the subject of medicine were being overthrown in favour of those of the Roman physician, Galen (AD 131-201).[18] Galen's works had been well-known by medieval physicians; in contrast to Aristotle's inductive-deductive reasoning and method of observation, Galen combined the actual practice and observations of medicine with philosophy.[19] Apart from methodology, the chief differences between Aristotelianism and Galenism regarding women's bodies occurred in the understanding of the female's role in reproduction. Aristotle saw women as passive and subordinate in conception, just as he considered them to be in other aspects of life; the female could not concoct or emit semen, which contained "the principle of the Soul" , and contributed only 'matter' to the foetus.[20] In the matter of sex differentiation of the foetus, Aristotle reiterated a sexual hierarchy. The sex of a foetus was determined by the proportions of semen and menstruum. The male principle had to gain "mastery" over the matter to create a male; if the sperm was "worsted", a female resulted.[21] In contrast, Galen saw women as 'imperfect' males. Men, he claimed, were more perfect than women because of "his excess of heat" which was "Nature's primary instrument."[22] He allowed, however, that the Creator would not "make half the whole race imperfect and, as it were, mutilated" unless it were advantageous.[23] While Galen perceived the female reproductive organs as inversions of the male organs, he also asserted that the female 'seed', which was scantier, colder, and wetter than that of a male, had a contributive property in conception.[24] According to Galen, sex determination had several variables, primarily depending on which side of the uterus the male semen had been deposited and from which testes the semen had been emitted. Thus, since the left side of the uterus and the left testes received less purified and cooler blood than the right sides, a daughter would result if the semen from the left testes was stronger; conversely, a foetus growing on the right side of the uterus received more heat and would therefore become male.[25] Despite the differences, both Aristotelian and Galenic theory established a clear hierarchy, paralleling that of the patriarchal culture, with men being superior, perfect creatures.

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[14] Theodore Brown, The Mechanical Philosophy and the 'Animal Oeconomy' (New York: Arno Press, 1981), 18-27.

[15] Robert Frank, Harvey and the Oxford Physiologists (Berkeley and Los Angeles: University of California Press, 1980), 48.

[16] Ibid., 49.

[17] Charles Webster, The Great Instauration (New York: Holme & Meier Publishers, 1975), 138-141.

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[18] Maclean, Renaissance Notion, 29-30.

[19] Nancy Siraisi, Medieval and Early Renaissance Medicine (Chicago and London: University of Chicago Press, 1990), 10, 58; Joan Cadden, Meanings of Sex Difference in the Middle Ages (Cambridge: Cambridge University Press, 1993), 31.

[20] Aristotle, Generation of Animals trans. A.L. Peck (Harvard University Press, 1943), Book I.20, 103, 109; Book II.3, 173.

[21] Ibid., Book IV.1, 391.

[22] Galen, excerpts from On the Usefulness of the Parts of the Body, 41-42 in Woman Defamed and Woman Defended ed. Alcuin Blamires (Oxford: Clarendon Press, 1992), 41.

[23] Ibid., 42.

[24] Ibid., 42; Cadden, Meanings of Sex, 35.

Although both theories were questioned intensively during the fifteenth and sixteenth centuries, scholars continued to form conclusions consistent with traditional doctrines. Indeed, even when developing arguments which opposed ancient authorities, scholars decontextualized bits and pieces of Aristotle and Galen, which actually would contradict their new arguments if taken in proper context, in order to support their arguments with the 'authority' of the old sources.[26] For example, although anatomists disputed the Galenic and Aristotelian understanding of female genitalia, they still had little observational evidence with which to support their contentions. Even Falloppio inadvertently utilised the traditional view when he asserted that he was unable to see anything like semen in the female 'testes', thus continuing to perceive the female genitalia as that of an inverted male.[27] Most importantly, despite the variety of medical opinions and debates, one assumption continued to form the basis for the debates: females were inferior to males.

Scholarly debates regarding women's physiology and role in conception continued to be divided along the lines of Galenism and Aristotelianism during the Renaissance. One of the central questions was whether or not females were imperfect creatures. Prior to 1600, the argument tended to reiterate Aristotle and Galen, claiming that the female was less perfect than the male; by 1600, such a concept became unpopular as the uterus was seen as admirable for its role in procreation. Nonetheless, the Galenists argued only that women were equal to men in the role of procreation. In other physiological matters, women's natural coldness and moistness predisposed them to physical and mental inferiority.[28] A related debate centred on the efficacy of female semen in conception. The divisions blurred between neo-Aristotelians and Galenists as the neo-Aristotelians could not agree on what Aristotle's opinion had been. The predominant view was derived from Galen, that women emitted semen, but that it was colder and less active than that of the male. The degree of activity was the subject of argument. Galenism again seemed to be the dominant trend, in that the most common resolution was that female semen contributed to both the form and the matter of the embryo. The woman's menstrual blood provided matter.[29] However, the concept of the female reproductive role underwent another change toward the end of the seventeenth century. William Harvey advanced the theory that women did not emit seed; rather they possessed ovum with which the male seed mingled. Furthermore, he argued that male seed could not enter the womb, and therefore had power to act at a distance through sympathy or magnetism.[30] This is not, however, to say that Harvey's theory was widely accepted. Mauriceau, a French physician, considered the theory "a great absurdity to believe: for the contrary may easily be discovered."[31] Although the theory was not popular until the early eighteenth century, it had once again placed women into a passive role in procreation. Female 'equality' in reproduction was short-lived; by the end of the century, scholars still considered women to be imperfect creatures, and had once again begun to assume females to be passive in procreation.

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[25] Cadden, Meanings of Sex, 35.
[26] Maclean, Renaissance Notion, 35.
[27] Ibid., 36.

Scholars also considered topics specific to women: menstruation and the uterus. During the Middle Ages, menstruation had been seen as unclean, a taboo which at least dated back to Aristotle and Pliny. Contrasting the medieval perspectives and even the theological texts of the Renaissance, formal medicine began to stress the harmlessness of menses, perceiving them as merely excrement. By the late Renaissance, physicians claimed that menstruum was only malignant when the woman was ill.[32] Midwife Jane Sharp, who was conventional in her understanding of medicine, scoffed at the myth that menstrual blood might destroy plants and trees or cause madness in dogs; instead, "If the woman be in good health, her monthly courses are no bad blood for quality."[33] Likewise, the belief that menstrual blood converted into breast milk during pregnancy was prevalent. Thomas Willis described how the blood was "brought by the Arteries into the Glands destinated here and there for receiving it before it is assimilated . . . if the Milk be driven from the Breasts, it restagnates again towards the Womb."[34] Several scholarly questions focused on the uterus; most important were whether or not the uterus caused illness and what was the relationship between a woman's imagination (mind) and her uterus. Within scholarly medicine, the uterus was seen as the source of many 'mental' health problems affecting women: hysteria, excessive desire for coitus, lovesickness, melancholia, listlessness and irrationality. Similarly, the unborn children were considered vulnerable to the woman's imagination, resulting in birthmarks and deformities.[35] The female body was understood to be weaker than the male body. After Jane Sharp had enumerated the variety of problems caused by having a womb, she concluded that "If one womb in a woman be the cause of so many strong and violent diseases, she may be thought a happy woman of our sex that was born without a womb."[36] Other medical practitioners also saw women as being especially prone to diseases; they thought women to be more subject to fevers and ill vapours than men, in addition to suffering from 'women's' problems and general bad health.[37] Women did, on the whole, seem to suffer from more medical problems than men. In addition to the illnesses common to both genders, the female life cycle centred around reproduction: menstruation, conception, pregnancy, miscarriage/abortion, childbirth and lactation.[38] All of these areas had potential health problems. Thomas Willis went contrary to the commonly accepted theories about women's health when he suggested that "any time a sickness happens in a Woman's Body . . . we accuse the evil influence of the Womb (which for the most part is innocent)."[39] Although medical scholars had cleared women's menstruation of its previous stigma, they still considered the uterus to be an unruly and unhealthy organ.

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[28] Ibid., 32-33, 36. Based on the dominant humoral theories, heat was seen as the creative and positive force, providing strength, vigour, courage and intellect; it is especially relevant here as intellect required heat to be driven into the head. Men were considered to have more heat than women.

[29] Maclean, Renaissance Notion, 36-37.

[30] Argument as cited. Eccles, Obstetrics and Gynaecology, 32, 35; Merchant, Death of Nature, 155-163. In 1677, Anton van Leeuwenhoek discovered spermatozoa; however, his findings received little contemporary discussion (Eccles, 41).

[31] Quotation as cited, from F. Mauriceau The accomplisht midwife trans. Hugh Chamberlen (1673). Eccles, Obstetrics, 32.

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[32] Maclean, Renaissance Notion 39-40.
[33] Sharp, The Midwives Book, 143.
[34] Quotation as cited, from T. Willis, The London practice of physick (1685). Eccles, Obstetrics, 52,
[35] Eccles, Obstetrics and Gynecology, 40-41. The idea of imagination causing birth defects was not refuted in detail until 1727 by J.A. Blondel.
[36] Sharp, The Midwives Book, 335.
[37] Linda Pollock, "Embarking on a Rough Passage: the Experience of Pregnancy in Early-Modern Society", 39-67 in Women as Mothers in Pre-Industrial England (London and New York: Routledge, 1990), 45.
[38] Crawford, "Pre-Industrial England", 63.

The greatest change in early modern medical thought occurred through the study of anatomy. Public dissection encouraged the conviction that the dissected body was the source for anatomical knowledge. The hidden interior of the body, before only understood through the symptoms of disease, now became visible for all to see.[40] Traditionally, the male and female genitalia were considered to be inversions of one another: uterus = penis and ovaries = testes, or vagina = penis, uterus = scrotum. The male genitalia developed outside of the body because of the man's greater heat.[41] Maclean suggested that with the study of anatomy through dissection such parallelism was abandoned by the 1600s.[42] However, Thomas Laqueur has demonstrated the existence of a 'one-sex' model of gender which anatomical studies reinforced and which continued into the eighteenth century. In 1559, Renaldus Columbus 'discovered' the clitoris, and described it "as a sort of male member" that became "a little harder and oblong" during sexual arousal. Within the traditional model of inverted genitalia, this meant that the woman had two penis-like members.[43] Similarly, Andreas Vesalius, one of the foremost Renaissance anatomists, represented the female organs as male inversions in all three of his works.[44] Even Kaspar Bartholin, a sixteenth-century anatomist who questioned the traditional parallels--which part of the female organs specifically were the penis and scrotum--finally resorted to using the language of parallelism to describe his findings. For example, he simultaneously saw the orifice of the womb functioning like the "nut of the yard" and swelling in "sundry ways according to the lust of the woman", while the clitoris also was "the female yard or prick."[45] Despite actually examining the interiors of bodies, the anatomists reinforced the traditional concept of inversion. Laqueur notes that the dominant ideology dictated how the organs were seen and what similarities and differences were important. The diagrammatic representations of the genital organs were not merely images or errors on the part of the anatomists; rather, they resulted from an entire world view in which women were inversions of men.[46] Anatomy, which had the power to change the ways in which people thought about the human body, reinforced the preconceived notions of women as inverted males, reflecting the extent to which formal medicine had absorbed the Galenic model of the female body.

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[39] As quoted from Thomas Willis, An Essay of the Pathology of the Brain and Nervous Stock... (London, 1667) by Martensen, "Transformation of Eve", 107.
[40] Duden, Woman Beneath, 18; Laqueur, Making Sex, 70.
[41] Laqueur, Making Sex, 79; Maclean, Renaissance Notion, 33.
[42] Maclean, Renaissance Notion, 33.
[43] Laqueur, Making Sex, 64.
[44] Ibid., 81.

By 1600, misogyny had been deeply entrenched in formal medicine. Some historians have assumed that this blatant misogyny directly affected the medical treatment received by women. For example, Hilda Smith has perceived a direct link between gynecology and ideology. She claims that "many opportunities existed for either useless or even harmful treatments to be employed" and depicted women as passive in the physician/patient relationship.[47] Although Carolyn Merchant does not specifically discuss medicine, she examines the effects of the development of early modern science on the relationships between man and nature/woman. Like Smith, she assumes a direct link between the dominant ideology and the reality for women.[48] This assumption does not consider other social trends and cultural beliefs apart from what was essentially an elite medical knowledge; cultural beliefs would have modified that knowledge.

First of all, there were several types of medical practitioners in early modern England, ranging from university-trained physicians to the local healers; a professional monopoly did not exist. Several historians have detailed the different methods of healing and the practitioners' varied levels of background knowledge.[49] The medical consumer had a multitude of choices available, ranging from university-trained physicians to housewives. Even the normally jealous 'elite' physicians accepted the co-existence of different types of healing. For example, Francis Herring, an early seventeenth-century Fellow of the Royal College of Physicians, considered surgeons and apothecaries to be subordinate to physicians, but acknowledged that physicians needed assistance: "the Physician, as a great Commander, hath as subordinate to him cooks for Diet, the surgeons for manual Operation, the Apothecaries for confecting and preparing medicines."[50] Several estimates have been made on the numbers of medical practitioners in early modern England. Alan Macfarlane has suggested that in seventeenth-century Essex, every village had a 'cunning-man' within a ten mile radius. Margaret Pelling and Charles Webster estimate that about 250 unauthorised practitioners practised in London between 1581 and 1600. For the seventeenth century, John Raach has identified 814 known physicians in England. Margaret Pelling has also identified 150 members of the Barber-Surgeons' Company in Norwich (1550-1640), which included physicians.[51] Such estimates, however, do not account for the majority of unlicensed, or 'non-professional', practitioners about whom no records were kept. Not only were most practitioners not university educated, but few had been formally apprenticed and associated with gilds, or had even received a bishop's or university license. Most frequently, practitioners were informal, neither having official qualification nor necessarily practising full-time, and had acquired medical knowledge through casual means.[52] Thus, the number of practitioners in existence was far higher than the official numbers of 'professional' practitioners would indicate and, most importantly, most practitioners had gained their medical knowledge from popular sources rather than formal training.

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[45] Ibid., 92.
[46] Ibid., 82, 88.
[47] Smith, "Gynecology and Ideology", 102.
[48] Carolyn Merchant, The Death of Nature.
[49] See Beier, Sufferers and Healers; Mary Fissell, Patients, Power and the Poor in Eighteenth-Century Bristol (Cambridge: Cambridge University Press, 1991); Margaret Pelling and Charles Webster, "Medical Practitioners", 165-236 in Health, Medicine and Mortality in the Sixteenth Century (Cambridge: Cambridge University Press, 1979); Porter and Porter, Patient's Progress; Pouchelle, Body and Surgery.

The first source of medical knowledge would have been oneself or one's family and friends; most people had a basic knowledge of medicine. Before ever seeking medical assistance, people treated themselves. Even after receiving assistance from medical practitioners, people were often required to make or to apply their own remedies.[53] Nonetheless, there were many other types of assistance to be had. Within the community of late sixteenth-century Norwich, for example, clergymen or gentlemen and their wives provided medical assistance for a nominal fee or free. Surgeons, midwives, and 'cunning' men or women offered their services. In difficult cases or special complaints, such as the stone or cataract, advice could be sought from itinerant practitioners.[54] Patients might use the services of one or several practitioners, searching until satisfied with the results. The case of Mrs. Swallow's daughter demonstrates the typical use of multiple healing forms. The child had received leg burns, which her mother treated with a yellow salve. Only when the salve caused the leg to become blistered and itchy, did Mrs. Swallow call the surgeon Joseph Binns. Mrs. Swallow also applied a red balsam which she had obtained previously from a Dr. Wright to treat another type of burn. Binns continued to use the balsam , but added two other ointments and a barley water application, curing the patient within two weeks.[55] Not only does this case indicate that Mrs. Swallow applied her own knowledge of medicine, but that she consulted at least two types of healers for the injury. In addition to the 'trained' or apprenticed and licensed practitioners, several other types of medical practitioners co-existed in the medical 'marketplace'.

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[50] As quoted by Beier, Sufferers and Healers, 10.
[51] Beier, Sufferers and Healers, 27.
[52] Pelling and Webster, Medical Practitioners, 233.

Physicians and other practitioners, like their patients, were products of their popular culture. Several recent studies illustrate the practitioners' inner tensions between the culture which they shared with their patients and their medical training. In early modern medicine, medical practitioners needed to listen to patients' complaints since the workings of the interior of the living body remained a mystery, despite anatomical research. Only the patient could reveal the interior of the body to the physician through her words.[56] The power of the patients' spoken words would not change until the late eighteenth century with the development of a medical vocabulary that made the patients' words inferior and unnecessary.[57] In her study of the writings of the eighteenth-century

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[53] Beier, Sufferers and Healers, 130.
[54] Pelling and Webster, Medical Practitioners, 233.
[55] Ibid., 76-77.
[56] Duden, Woman Beneath, 87.
[57] Mary Fissell, Patients, Power, and the Poor, 153-158.

German physician Johann Storch, Duden discussed how two forms of discourse occured: his own words and his conceptions of the women's words. A few differences in medical thought between the two emerge clearly. For example, where Storch might want to entice stagnant blood to open up, the women talked of expelling the bad blood. Certainly there were theoretical differences between the elite and popular concepts of medicine, but in actual practice Storch's treatments and those requested by the patients were very close.[58] Storch was also reluctant to dismiss popular beliefs, such as magic. Based on his 'rational' training, Storch criticised magical practices and commented that the belief in the powers of menstrual blood was a fabrication. Yet, when Storch was asked as the town physician to attest to the harmlessness of a widow's menstrual blood used in a love spell, he was unable to do so with certainty.[59] Similarly, Marie-Christine Pouchelle has analysed the symbolism of the body, health and illness in Henri de Mondeville's fourteenth-century treatises. On the one hand Mondeville was determined to show himself to be separate from empirics and often criticised their treatments; on the other hand, he was not above using 'empiric' remedies when they were efficacious.[60] Pouchelle also examines in detail how Mondeville, being a man of his culture, used the common imagery of medieval society to describe the body.[61] Ronald Sawyer has studied the ways in which Richard Napier, a seventeenth-century English astrological healer and clergyman, related to his patients' beliefs of witchcraft. Despite his 'elite' training at Oxford, Napier had a consistently tolerant attitude toward the beliefs of his patients. On occasion, he refused to sustain the wilder accusations of witchcraft, but generally, he acted to channel the accusations and provide 'supernaturally efficient' remedies.[62] Such studies suggest that cultural beliefs and the expectations of patients modified the professional/elite training of practitioners.

No clear boundary existed between 'popular' and 'elite' beliefs during the seventeenth century. Even the distinction between popular and elite is problematic. Not only were such distinctions ignored during this period, but historians have used the term 'popular' to encompass all medical knowledge, except that of scholars, from that of the wisewomen to the literate middle class. Moreover, this distinction places the two medical systems in polar opposition to each other, which is fallacious.[63] During the early modern period, any boundary between formal and elite medicine was further eroded with the widespread publication of medical books in the vernacular for a general audience.[64] As Audrey Eccles has pointed out, when dealing with the topics of sexuality, conception, and pregnancy/menstruation, it is difficult to determine whether a scientific 'fact' has become common knowledge, or whether a popular belief has been rationalised into science. Furthermore, within such a permeable medical culture, the science of one generation could easily become old wives' tales in the future.[65] Since 'science' and popular knowledge were often entwined, it is necessary to explore alternative concepts of the female body beyond the realms of university or formalized learning. Physicians and other practitioners were ultimately products of their culture, whether or not they subscribed to the popular ideas.

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[58] Duden, Woman Beneath, 104-106.
[59] Ibid., 70-71.
[60] Pouchelle, Body and Surgery, 65-67.
[61] Ibid., Part II, "The Body and Its Diseases: Submerged Images", 91-197.
[62] Ronald C. Sawyer, "'Strangely Handled in All Her Lyms': Witchcraft and Healing in Jacobean England", 461-485 in Journal of Social History 3, 22 (1988/9), 463.

Many of the academic concepts, such as the idea of women as inverted males, had filtered into popular usage over time. The writer Montaigne retold Ambroise Paré's story about "Marie" who had been raised female. However, in the heat of puberty, she jumped across a ditch and "at that very moment the genitalia and the male rod" descended. After some debate, the Bishop and an assembly approved the transformation, giving Marie the name of Germain and male clothing.[66] The determination of gender was also debated in the law courts. In seventeenth-century Holland, for example, Henrika Schuria, a masculine-looking female who "had grown weary of her sex" dressed as a man and enlisted in the army. She was later accused of "immoral lust" when she was caught taking the dominant role in intercourse with another woman. Her clitoris "equalled the length of half a finger and in its stiffness" was like a penis. The judge, however, found her guilty of the crime, not considering her penis-like member sufficient to be male; in order to be male, a male part had to descend.[67] Marie de Marcis, however, in sixteenth-century Rouen, received the right to become a man. She fell in love with another female servant and revealed a penis to her; they sought to marry. At that point, she was accused of sodomy and nearly burned for her crime. Not only had her master and mistress testified to the regularity of her menses, but she could not produce her penis. Dr. Jacques Duval, however, probed her vagina and upon finding a projection, rubbed it until it ejaculated. The Court ordered her to wear female clothing until she was 25 and to refrain from sex.[68] These anecdotes demonstrate that people considered it possible for male organs to descend from the female interior and for gender to be permeable. Although scholarly medicine purposely paralleled male organs and the inferior female organs, the defining badge of gender within popular culture was the possession or absence of a distinct penis, not a penis-like member. Nonetheless, this did not automatically place the female body into a lower position; indeed, the female body of popular culture was seen as powerful rather than inferior. The female body represented life and death simultaneously; breast milk, menstrual blood, and the female body possessed magical properties that males lacked. However, as in elite theories, the body--especially that of the female--became devalued, an object to be controlled, throughout the seventeenth century.

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[63] Beier, Sufferers and Healers, 30-31; Andrew Wear, "The Popularization of Medicine in Early Modern England", 17-41 in The Popularization of Medicine 1650 - 1850 ed. Roy Porter (London and N.Y.: Routledge, 1992), 17-18.

[64] Wear, "The Popularization of Medicine", 22, 24.

[65] Eccles, Obstetrics and Gynecology, 33.

[66] As cited in Laqueur, Making Sex, 127.

The 'peasant body' described by Rabelais during the sixteenth century had many similarities with the ways in which women's bodies were perceived during the seventeenth century. The conception of the peasant body was of a free-flowing body, with permeable boundaries between itself and the outside world, at once absorbed and absorbing. Without clear definition, the body was constantly reconstructing and recreating. The orifices of the lower body, especially the sexual organs, were places of transference between the body and the world, the point at which the body could create beyond itself.[69] Similarly, the body was a place of inner transformations, wherein diseases could mutate and flow between one organ and another.[70] Both of these 'popular' attitudes and beliefs about the body were doubly true for women. Breast milk was thought to be menstruum which had been diverted to the breasts to provide nourishment to the baby after birth.[71] Moreover, the interior of the female body, "a worlde of yt selfe", was at once a receptacle for and creator of life--the ultimate form of transformation, the most secret of mysteries.

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[67] As cited in Laqueur, Ibid., 137-8. Henrika was, however, given a man's punishment, exile and castration.
[68] As cited by Ibid., 136.
[69] Mikhail Bakhtin, Rabelais and His World, trans. Helene Iswolsky (Cambridge, Mass.: M.I.T. Press, 1968), Chapters 5 and 6.

The power that the ability to create life conferred on women can be seen, conversely, in the belief that women could cause the baby *in utero* to be born deformed or monstrous. During the sixteenth century, one scholarly debate was about how 'monsters' were created. Monsters, or imperfect births, were thought to result from having sexual intercourse while the woman was menstruating. In this case, the male seed would be unable to "cleanly unite itself with the blood of the woman"; in addition to causing leprosy, scabies, or other skin problems, it could cause the child to be deformed or lunatic.[72] Ottavia Niccoli notes that the few historians who have examined this theme have assumed that the debate was based on an unchanging taboo on intercourse with a menstruous woman, as proscribed in the Book of Leviticus. However, Niccoli found biblical references only to the impurity of having intercourse during menstruation, not to an association between leprosy and menstruation.[73] It was not until 1559 that Lieven Lemnes affirmed a cause-effect relationship between menstrual conception and monstrous births, arguing that Moses had forbidden intercourse during menstruation and that, in the event of conception, the menstrual blood would provide corrupt matter to the foetus. Ambroise Paré provided further support for this theory in his Des Monstres et Prodiges (1573), citing 4 Ezra, an apocryphal Book. The passage which he used for his argument, and which was later cited frequently in the debate, read that menstruating women will give birth to monsters. This was the result of a copyist's error; the original Hebrew read that, as one of the signs of the end of the world, "women will give birth to monsters."[74] By the seventeenth century, the theory of monsters had been forgotten by elite medicine. However, through the process of diffusion, the idea had become entrenched in popular culture, where it had not formerly existed.[75] In 1671, Jane Sharp warned her readers of the variety of problems for "women that have had company with men" during menstruation. They could produce "Monsters of all sorts to be formed in the womb", such worms, toads, mice and snakes, and "distorted, imperfect, ill qualified Children".[76] Monsters could also be created through the power of the woman's imagination during intercourse.[77] The mother's imagination or actions could create several other types of problems for the unborn child. By eating strawberries, the woman might cause a strawberry mark; eating pickled onions could result in birthmarks; seeing a hare might result in a hare lip, while seeing a snake, in green eyes.[78] These ideas lasted well into the eighteenth century amongst practitioners, and far longer within popular culture.[79] Thus the pregnant woman held a great deal of power over the unborn child. Women were also intimately associated with death. They were the ones who tended to the sick and the dying and prepared the body for laying out.[80] In many cultures, this has resulted in a ritual impurity becoming attached to those involved.[81] Moreover, women could create death as well as life within their bodies. Molas (false pregnancies or uterine growths) could prove deadly to the woman herself, or an unborn child could be "opprest by them [molas]".[82] Within her dark mysterious interior, the world of her own, the woman had the power to create life, be it perfect or monstrous, and to cause death.

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[70] Duden, Woman Beneath, 106-110.

[71] Crawford, "Pre-Industrial England", 65.

[72] Maclean, Renaissance Notion, 39-40, discusses how menses were debated as being unclean, but does not specifically correlate the debates about monsters and menstruation. Quotation from Flemish physician Lievin Lemnes in Ottavia Niccoli, "'Menstruum Quasi Monstruum': Monstrous Births and Menstrual Taboo in the Sixteenth Century" trans. Mary Gallucci, 1-25 in Sex and Gender in Historical Perspective eds. E. Muir and G. Ruggiero (Baltimore: Johns Hopkins University Press, 1990), 1-2.

[73] Niccoli, "Menstruum Quasi Monstruum", 10-11. The earliest reference to a link was in one of the canons of the Nicene Council (325 A.D.).

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[74] Ibid., 10-15.
[75] Ibid., 18-19.
[76] Sharp, The Midwives Book, 109, 111.
[77] Ibid., 111.
[78] Mary Chamberlain, Old Wives' Tales (London: Virago Press, 1981), 240-241.
[79] Crawford, "Pre-Industrial England", 65.
[80] See for example, Samuel Pepys' description of his brother's death and burial (March 15-18 1663/4) in The Diary of Samuel Pepys vol. 5 ed. R.C. Latham and W. Matthews (London: G. Bell and Sons Ltd., 1970), 85-91.
[81] James Brain, "An Anthropological Perspective on the Witchcraze", 15-27 in The Politics of Gender ed. Jean Brink, Allison Coudert and Maryanne Horowitz (Missouri, 1987), 15-16.
[82] Sharp, The Midwives Book, 107.

Women's bodily emissions possessed magical and curative properties. For example, breast milk was often used in medical recipes for treatment of the eyes and ears, for hysteria, insomnia, faintness, and easing childbirth.[83] Moreover, it was so powerful that it could be used on its own: "Take foure spoonefull of another woman's milke, & giue it the woman to drinke in her labour, and shee shall be deliuered presently" reads one recipe.[84] Marylynn Salmon discusses how the use of breast milk as a cure reflected the life-giving power attributed to milk. The white, frothy nature of the milk indicated that it was highly concocted, like male semen. Whereas semen was needed to create life, breast milk sustained it.[85] Menstruation was seen less positively, but was a powerful bodily emission nonetheless. In contrast to breast milk, it was considered to be dangerous and impure. Pliny's assertions that menstruating women could sour wine, kill grass and buds, discolour mirrors and blunt knives, were still current in the seventeenth century.[86] To this, popular culture added that women should not salt pork or enter a dairy while menstruating.[87] The female cycle seemed mysterious, governed by the moon and by the number seven. Its properties varied. If a menstruous woman's hair were placed in dung, it would become a serpent. Yet it was a prime ingredient in love potions and in promoting or hindering conception. As a cure, it was used for the bites of mad dogs, the falling sickness, and agues. Furthermore, it might prevent hail and lightening.[88] Despite the decline in magical beliefs throughout the seventeenth century, such ideas have endured in a moderated form into the twentieth century.

The power of the female body was not limited to its emissions. Luisa Accati has examined how the predominance of women as witches was linked to the sexuality of the female body in early modern Italy.[89] Fitting with Bakhtin's analysis of the peasant body, the locus of power was located in the lower orifices. For example, on 19 May 1645, Madalina del Conte confessed to the Inquisition at Brazzano (Friuli) that ten years ago she had made her young niece Zannuta "ride naked on a yoke and go around through the fields imploring often at dawn, 'Flee, flee, furry caterpillars or my cunt will eat you.'" She further remembered that her mother had once lifted her skirts at a storm, crying against the wind, "Nothing, nothing may do more harm than this ass."[90] In contrast, the males in the town of Brazzano questioned about magical activities drew their magical knowledge from books or utilised herbs and whispered spells.[91] Women could also draw negative power from their bodies. Only women could bring death because only they could create life; likewise, only a woman could dry up another's breast milk, because only women could lactate.[92] The time of maximum female potency in Friuli, however, was pre-menarche virginity. Upon reaching menarche, a woman's vital force was to be directed into procreation. This is the reason Madalina needed Zannuta's assistance in chasing away the caterpillars.[93] A similar study has not been done for English peasants. However, the superstitions surrounding childbirth and menstruation are suggestive that the English might have shared a deeper belief in the powers of the female body. Similar to the confession of Madalina, an English tradition claimed that if a young menstruating virgin touched the posts of a house, the house would be protected from all mischief.[94] Popular witch belief suggested that old women tended to be witches; however, in such cases, the old woman's sexuality was depicted as perverse and lascivious.[95] In early modern popular culture, the female body was a potent force, unparalleled by the male body. Where scholars argued that men's bodies were perfect, popular culture did not attribute any potency to men's bodies. However, the female body was becoming progressively stripped of power as magical beliefs declined, relegated to mere superstition and old wives' tales.

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[83] Marylynn Salmon, "The Cultural Significance of Breastfeeding and Infant Care in Early Modern England and America", 247-269 in Journal of Social History (1994), 249-250.

[84] Markham, Countrey Contentments, 36.

[85] Salmon, "Significance of Breastfeeding", 251.

[86] Patricia Crawford, "Attitudes to Menstruation in Seventeenth-Century England", 47-73 in Past and Present 91 (1981), 59.

[87] Ibid., 61; Chamberlain, Old Wives' Tales, 231.

[88] Crawford, "Menstruation", 59-60.

[89] Luisa Accati, "The Spirit of Fornication: Virtue of the Soul and Virtue of the Body in Friuli, 1600-1800" trans. Margaret Gallucci, 110-140 in Sex and Gender in Historical Perspective ed. E. Muir and G. Ruggiero (Baltimore: Johns Hopkins University Press, 1990).

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[90] Ibid., 111-112.
[91] Ibid., 115-117.
[92] Ibid., 121.
[93] Ibid., 120.
[94] Crawford, "Menstruation", 60.
[95] The alleged carnality of witches is discussed most explicitly in Heinrich Kramer and James Sprenger, Malleus Maleficarum, trans. Rev. Montagues Summers (London: Pushkin Press, 1951).

Women's perceptions of their own bodies adapted both the 'elite' and 'popular' views. In the past, historians of medicine have not examined what women thought about their own bodies, preferring to concentrate on the easily accessible sources of the male medical practitioners. Admittedly, it is difficult to obtain sources of women's words and thoughts, especially on the subject of the body. The discourse on women's bodies by women has largely remained unwritten. However, from existing sources, women's thoughts about their health emerge. Women did not entirely adopt the patriarchal views of formal medicine. For example, although pregnancy and childbirth were glorified as women's ultimate goal, women were terrified of the attendant problems. Yet women could also modify prevailing sterotypes, as in cases of emotional illness or miscarriage. Such stereotypes made it easy for a woman to manipulate them; a woman could exert control over a situation through an emotional illness, or induce an abortion and claim a miscarriage. In agreement with formal medicine, however, women perceived themselves as vulnerable to ill health and had an uncomfortable relationship with their bodies. Intense emotions could imprint themselves on the female body; an absence or over-abundance of menstruation could create further health problems; and pregnancy was a time of almost constant 'illness' and potential death.

To seventeenth-century people, there were a variety of dangers to their bodies; any problem could imprint itself on one's body, creating a health problem. For example, if one were to get caught in a sudden rain shower, one's blood could become chilled and begin to stagnate.[96] 'Catching a cold' was a literal term, and resulted in a variety of problems. Samuel Pepys often described how 'cold' acted on him. Once, the cold in his legs, from not wearing his gown, caused 'wind'; another time, he caught a cold in his head and throat because he had cut his hair so close to his head.[97] A different sort of danger, that of intense emotion imprinting itself upon the body, existed for women. Male diarists and correspondents do not mention emotion as a cause of their ailments, yet women autobiographers and diarists frequently noted a relationship between illness and emotion; intense negative emotions were thought to act most strongly upon the female body. In Duden's analysis of Johann Storch's casebooks, she determined that anger, to the German women, was an inner poison; it was described as a heat, a surge, an inner cramp, congestion in the womb, or choking. If the anger 'swelled' too much, it would stagnate inside and cause many other pains. Storch's patients consulted him in order to rid themselves of the poison before it became worse.[98] Although the English sources do not discuss anger as a sickness, despair, anxiety, grief and fear are mentioned as triggers of illness. Anne, Lady Halkett nearly died of a sudden 'distemper' after she learned not only that her lover, 'C.B.', was on the verge of death, but that he had lied to her that he was unmarried.[99] The Countess of Warwick was recuperating from the small-pox when she heard of the beheading of Charles I and took a turn for the worse, having "a great abhorrence of that bloody act."[100] Both Alice Thornton and the Countess of Warwick became ill after members of their families suffered. Alice Thornton became very ill as her sister lay dying; she haemorrhaged severely after giving birth because one of her children had convulsions; when her husband had his first palsy attack, she fell into a violent passion and swooning fits. Likewise, the Countess of Warwick had "very ill fits" after her husband died of convulsions.[101] Lady Zouche suffered from "fitts of the mother" after her son "drew out his sword and threatened to kill his Mother".[102] Richard Napier, like Storch, had a significant number of female patients. Of 1286 patients complaining of a mental disorder, 538 were female; one-fifth of these women also complained of 'female' ailments as well as mental problems. The ongoing discomfort and pain of such problems could have increased mental stress. Moreover, 767 (over half female) complained of frustrating relationships and distressing experiences. Michael Macdonald suggested that the high proportion of female patients in Napier's practice resulted from a combination of individual tendencies toward 'melancholy' with the patriarchal society which limited women's abilities to control disturbing situations.[103] Thus, in some situations, an emotionally-caused illness could be a woman's attempt to exert control over her situation. Nonetheless, as if the human body were not fragile enough with its 'permeable' boundaries, women also had an internal factor working against them--their own emotions.

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[96] Duden, Woman Beneath, 140.

[97] Latham and Matthews (ed.), Diary of Samuel Pepys, vol. 5 (August 14, 1664), 241; (March 4, 1663/4), 76.

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[98] Duden, Woman Beneath, 142-145.

[99] John Loftis (ed.), The Memoirs of Anne, Lady Halkett and Ann, Lady Fanshawe (Oxford: Clarendon Press, 1979), 32.

[100] Croker (ed.), Autobiography of Mary Countess of Warwick, 24-25.

[101] Beier, Sufferers and Healers, 236; Croker (ed.), Autobiography of Mary Countess of Warwick, 34.

[102] Dorothy Gardiner (ed.), The Oxinden and Peyton Letters 1642-1670 (London: Sheldon Press, 1937), Henry Oxinden to Katherine Oxinden (December 1, 1651), 172-174.

Medical practitioners emphasised the necessity of menstruation for a woman's good health. Although Hilda Smith has argued that the practitioners over-emphasised the importance of menstruation to the point of obsession, using brutal methods of intervention on their passive patients to bring on the menses, she neglected to investigate what the women thought of these attempts to induce menstruation.[104] Menstruation is the 'female' subject least discussed by women themselves. Men, whether theologians or physicians, had a great deal to say on the subject, with opinions ranging from considering menstruation unclean and malignant to being a healthful evacuation.[105] Evidence on what women thought about menstruation can be found only indirectly.

The absence of menstruation was associated with pregnancy, as it was one of the best signs of the state. Jane Hook, in one of the few direct references to menstruation, wrote that she thought she was with child, not having had "them but once which whas a mounth after I had been here."[106] Likewise, Elizabeth Pepys, "after the absence of her terms for seven weeks" told her husband that she might be pregnant.[107] Patricia Crawford suggested that attitudes toward menstruation would have varied depending on whether or not pregnancy was desired, such as in the case of one of Richard Napier's patients who expressed anxiety over not being pregnant because her terms troubled her so much. This links seventeenth-century women's concept of menstruation with their child-bearing capacity.[108] Women, like physicians, associated menstruation with a necessity for good health. In the 'traditional body' which Duden reconstructs for rural eighteenth-century

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[103] Macdonald, Mystical Bedlam, 37-39.
[104] Smith, "Gynecology and Ideology", 101-102.
[105] See Crawford, "Menstruation."
[106] Arthur Searle (ed.), Barrington Family Letters 1628-1632 (London: Camden Fourth Series, vol. 28 Royal Historical Society, 1983), Jane Hook to Lady Joan Barrington (28 December 1630), 172.
[107] Latham and Matthews (ed.), Diary of Samuel Pepys vol.1, (1 January 1659/60), 1.
[108] Crawford, "Menstruation", 70.

Germany, two 'fluxes' existed: inner and outer. The Eisenach women complained to Storch frequently about an inner flux which caused headaches, ringing ears, deafness, blindness, gout, rheumatism, womb suffocation, among many other internal problems. When the women spoke of the pains, it was of an oppressive burden, a violent assault and stream. The outer flux--bodily emissions, especially menses--were the mirror image, being considered more healthful. For example, by stopping up an oozing wound, it was thought that the illness would be driven back inside, causing further and, perhaps, more serious problems.[109] This conception of the body would have made the stoppage of the menses a serious ailment indeed. The menstrual blood would remain inside, either festering or trying to find another exit; many types of skin problems seemed to appear when menstruation was suppressed.[110]

Patricia Crawford found that medical commonplace books provide information on the importance of menstruation to women.[111] Other types of household books also provide such information. Many of these books contained medical recipes of special interest to women and often had several recipes for the stimulation of menstruation. In The Treasure of Hidden Secrets, for example, there are eight recipes (out of thirty specifically for women) to "induce the flowers". The author cautions the practitioner or woman to "look that the woman be not with child" before using it.[112] Recipes to stimulate menstrual periods could also be used to induce abortions. Likewise, Countrey Contentments contains sixteen women's recipes; while only one is to stimulate the menses, two others are to bring out a dead child.[113] It is unlikely that women would have been unaware of the potential 'side-effects' of such recipes. Linda Pollock has argued that women, in this way, found an advantage in manipulating the widespread belief that pregnancies were frequently miscarried. If women accepted the view that menstruation was necessary to their health, then it was acceptable--and important--to restart periods. Since women recognised the absence of menstruation to mean pregnancy, they were aware that they could be inducing an abortion. In turn, this increased the 'miscarriage' rate.[114] The London surgeon Joseph Binn's case of treating 'Mary' for amenorrhea was a common one. Nine days after he started the treatment of bleeding her, combined with emetics and laxatives, Mary's menses started. In such cases, there was a vague suspicion that perhaps the patient had been pregnant.[115] Menstruation, a subject of controversy for men, was seen as a natural event for women and indicated both her general health and her reproductive state.

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[109] Duden, Woman Beneath, 130-134

[110] Ibid., 122.

[111] Crawford, "Menstruation", 70-71.

[112] Anon., The Treasure of Hidden Secrets, Commonly Called, the Good-Huswives Closet of Provision, for the Health of her Houshold (London: Richard Oulton, 1637); Chapter 63.

[113] Markham, Countrey Contentments.

In contrast to menstruation, women had ambiguous feelings about pregnancy. While motherhood was the socially ideal role open to them, women perceived pregnancy to be a state of almost constant illness and recognised that childbirth could be fatal. Motherhood was seen by contemporaries and women themselves as a woman's primary function. The maternal role was often glorified, and those women who rejected it were condemned.[116] Lucinda Beier notes that women rarely attained a higher social status than when they were pregnant.[117] When a couple was childless, the wife was often labelled 'barren', and lacked both social status and respect.[118] Among the nobility, women bore children nearly every year, often conceiving within the first year of marriage. Women who breastfed, however, usually among the lower classes, tended to conceive at least at two year intervals.[119] Many women did want children. For example, Sarah Savage kept a diary after her marriage, recording the fluctuations of her hopes of having a child for the two years before she finally conceived.[120] Elizabeth Pepys' case is even more poignant. On two occasions she thought she might be pregnant, making "merry discourse", despite the unlikelihood of her husband being able to impregnate her.[121] Margaret, Countess of

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[114] Linda Pollock, "Embarking on a Rough Passage: the Experience of Pregnancy in Early-Modern Society", 39-67 in Women as Mothers in Pre-Industrial England, 59.
[115] Beier, Sufferers and Healers, 93.
[116] Salmon, "Cultural Significance of Breastfeeding", 252-260.
[117] Beier, Sufferers and Healers, 235.
[118] Crawford, "Construction of Maternity", 19.
[119] Dorothy McLaren, "Marital Fertility and Lactation 1570-1720", 22-53 in Women in English Society 1500-1800 ed. Mary Prior (London and New York: Methuen, 1985), 33-35,43-45.
[120] Crawford, "Pre-Industrial England", 74.
[121] Diary of Samuel Pepys vol.1 (January 1659/60), 1; vol. 5 (22 and 27 September 1664), 277, 281. Samuel Pepys had been operated upon for a kidney stone, which often rendered the patient sterile, as Samuel recognised himself.

Panmure, suffered from repeated miscarriages and sought advice from several practitioners and family members. Despite the number of remedies and measures that she tried over twenty years, she was unable to carry a child to term.[122] The stakes increased proportionately with a woman's status, primarily for the sake of bearing an heir.[123] Mary, Countess of Warwick, was "not much more than thirty-eight years" after their only son died, and wanted more children "to keep up the honour of that noble house."[124] This does not mean that women were necessarily happy to be pregnant. Maria Thynne expressed some displeasure at her pregnancy,

> the inexpressible singularity of thy [her husband's] love in the cogitations of *piamater*, I can say no more but that in the way of gratuity, the dogs shall without interruption expel their excremental corruption in the best room (which is thy bed).[125]

As a young woman, the Countess of Warwick had two children soon after her marriage. She "feared much having so many" and "out of a proud conceit" thought that if she "childed so thick it would spoil" her looks. Like her husband, she was also concerned that they would not be able to provide for many children with his then small estate.[126] Nonetheless, to many women, like Alice Thornton, the bearing of children was "the only excuse for their creation."[127]

To early modern women, however, pregnancy was an 'illness'. During pregnancy and childbirth, women's lives focused entirely upon their bodies. Pregnancy was the time when women were most likely to come into contact with some sort of medical practitioner. While a natural function, pregnancy was not expected to be comfortable, especially for the first few months. Around the 'quickening' in the third or fourth month, the woman might experience a temporary respite, but women in their last trimester were seen as subject to infections. Indeed, even a healthy mother could be a cause for worry.

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[122] Rosalind Marshall, "Seventeenth Century Midwifery: The Treatment of Midwifery", 32-37 in The Nursing Mirror, 15 December 1982.

[123] Crawford, "Construction of Maternity", 19.

[124] Croker (ed.), Autobiography of Mary Countess of Warwick, 31

[125] Alison Wall (ed.), Two Elizabethan Women: Correspondence of Joan and Maria Thynne 1575-1611 (Wiltshire Record Society vol.38, 1982; Devizes 1983), Maria Thynne to Thomas Thynne (August? 1604), 32-33. Wall suggests that *piamater* was a pun referring to Maria's impending motherhood.

[126] Croker, Autobiography of Mary Countess of Warwick, 32-33.

[127] As quoted in Beier, Sufferers and Healers, 235.

indicating that the foetus was not thriving.[128] In 1678, Frances Hatton wrote that she was well and "fat", making her "fear yt my child does not thrive."[129] The symptoms of pregnancy varied, but among them were minor ailments. It was thought that Elizabeth, Lady Cornwallis might be pregnant because of her sore throat and tooth-ache.[130] Women often discussed their pregnancies in terms of ill-health. The Countess of Bedford wanted to know whether Jane Cornwallis' "ill health this sommer have had so happy an issue as I hoped it wold"; Frances Hatton complained about her poor health and hoped that once she was "brought abed [she] shall be cured of all [her] illnes."[131] Pregnancy could also exacerbate other problems. Anne Conway's pregnancy was disguised by her headaches which intensified to the point that her family and medical practitioners thought that she was dying; nearly until she gave birth, everyone was uncertain whether she was "concluding of her own life", or "giving life to another."[132] Less severely, Brilliana Harley mentioned that her cold "trubelles [her] much more becaus of [her] being with childe."[133] In order to prevent any problems, Anne Clifford "kept in [her] Chamber and stirred not out of it till the latter end of March" after she felt the quickening in early December.[134] Another common problem during pregnancy was miscarriage, which was most often attributed to emotional stress or to a bad fall. Luckily, Alice Thornton did not miscarry despite "five great trials and hazards of miscarriage", including illness, fright at seeing a pen-knife, two business troubles and a fall down the stairs.[135] Anne Fanshawe miscarried triplets in 1660, which she considered to be a result of her "great hurry of business."[136] Similarly, Jane Hook took fright when her home was burgled and subsequently kept to her bed for two days with severe pains which she thought might indicate a miscarriage.[137] A miscarriage could also occur for no apparent reason as it did to Sir William Masham's wife; they "knowe not the cause of this."[138] Miscarriages were hard on the health, emotionally and physically. Brilliana Harley remained in bed for two months after she miscarried, while the Countess of Manchester worried over her niece being "soe very dangerously ill."[139] The experience of pregnancy for early modern women was one of constant illness.

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[128] Pollack, "Experience of Pregnancy", 46.

[129] Ibid., as quoted, 46.

[130] Jane Meautys Bacon (ed.), The Private Correspondence of Jane Cornwallis, 1613-1644 (London: S.& J. Bentley, Wilson, & Fley, 1842), Dorothe Randolph to Jane, Lady Cornwallis (1631/2, n.d.), 247.

[131] Ibid., Countess of Bedford to Jane Lady Cornawallis (27 October 1614), 29; Lady Hatton as quoted in Pollack, "Experience of Pregnancy", 46.

[132] Marjorie Nicolson (ed.), Conway Letters: The Correspondence of Anne, Viscountess Conway, Henry More, and their Friends, 1642-1684 (Yale University Press, 1930), Lord Conway to Major Rawdon (12 October 1658), 152-153.

[133] Thomas Lewis (ed.), Letters of the Lady Brilliana Harley (London: Camden Society, vol. 58, 1853), Brilliana Harley to Sir Robert Harley (8 May 1630), 5.

[134] D.J.H. Clifford (ed.), The Diaries of Lady Anne Clifford (Stroud, Gloucestershire: Alan Sutton Publishing Ltd., 1991), (2 October 1619) 79.

[135] As quoted. Beier, Sufferers and Healers, 233.

[136] Loftis (ed.), Memoirs, 141.

Pregnancy was also a time of intense fear for many women; the threat of dying either during childbirth or shortly afterwards was very real. The prayers in the religious diaries of Elizabeth, Viscountess Mordaunt and Elizabeth, Countess of Bridgewater reveal the anxiety that women felt before childbirth and the relief that they experienced afterwards.[140] Elizabeth Bridgewater referred to labour as her "greatest extremity" and prayed for strength; and if she were to die while in labour, she prayed that God would raise her to eternal life.[141] Elizabeth Mordaunt wrote about how God "turned [her] Heuynes into Joy" and thanked God for a safe deliverence, a perfect child, and the return of her own health.[142] Even the 'rational' Anne Conway took every precaution possible to ensure a safe childbirth; she was determined to have a particular type of eaglestone which was supposed to be most efficacious in warding off pain.[143] Although the maternal mortality rates were relatively low in England (6 to 7 percent), women perceived that their chances of dying in childbirth were high. Most women had known a woman who had died in childbirth or suffered from a difficult childbirth.[144] Gossip could be spread between friends, as with the Countess of Bedford and Lady Cornwallis who discussed the repeated miscarriages of a mutual acquaintance.[145] The experiences of Anne Halkett and Anne Clifford would have been common. Anne Halkett described how Lady Moray in child-bed "earnestly desired death many houres before itt came"; Anne Clifford reported the death of her grand-daughter who could not be delivered of a stillborn son.[146] At the age of 19, Alice Thornton was present when her sister Catherine died one month after prematurely birthing her sixteenth child; her labour had lasted fourteen days.[147] The travail of childbirth, as with the daily pains of pregnancy, was a time when the woman's body turned traitorous. The ambiguity of Lord Conway on whether his wife was breeding or dying is indicative of the state of childbearing: at the same time as a woman created life within her body, her own life could be lost.

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[137] Searle (ed.), Barrington Letters, Jane Hook to Lady Joan Barrington (January 1631), 173.

[138] Ibid., Sir William Masham to Lady Joan Barrington (26 November 1631), 220.

[139] Lewis (ed.), Brilliana Harley, Brilliana Harley to Edward Harley (31 January, 1 and 28 February, 6 and 20 March 1639/40), 78-9, 84-5, 87-8; Edward M. Thompson (ed.), Correspondence of the Family of Hatton (1601-1704) vol.2 (New York: Johnson Reprint Corporation, 1965; Royal Historical Society, vol.23), Countess of Manchester to Lord Hatton (2 August 1681), 5-6.

[140] Earl of Roden (ed.) The Private Diaries of Elizabeth, Viscountess Mordaunt (Duncairn 1856) contains xx prayers related to childbirth; Devotional Pieces by Elizabeth, Countess of Bridgewater (BL Egerton MS 607) contains 9 prayers related to childbirth.

[141] Devotional Pieces by Elizabeth, Countess of Bridgewater,56, 52.

[142] Roden (ed.), Private Diaries, 38.

[143] Nicolson (ed.), Conway Letters, Lord Conway to Major Rawdon (12 October and 21 December 1658), 152-5.

[144] Crawford, "Construction of Maternity", 22-23.

Throughout the seventeenth century, the concepts of scholarly medicine and popular culture reiterated and re-established the inferiority of women and the female body. Scholarly medicine reaffirmed the passivity of the female body; concurrently, the female body of popular culture, previously respected for its mysteriousness, had begun to lose its magic, and therefore, power. To a large extent, women themselves had absorbed the dominant patriarchal beliefs about women's bodies. Women understood their own bodies to be weaker and more vulnerable to illness and they believed that motherhood was the focus of a woman's life, at the risk of one's own health. This is not to say that women were left powerless. In fact, the perceptions of even 'elite' practitioners became modified by the ideas of popular culture and by the expectations of female patients. At the same time, women were able to manipulate dominant stereotypes, as in the case of miscarriage and inducing menses and abortions, to their own advantage. Ultimately, however, there is one striking similarity in how women, popular culture, and scholarly medicine perceived the female body: all were uneasy with the mysteries of the female body. Contained within this "worlde of yt selfe" were power and passivity, magic and monsters, and, most importantly, life and death; in such a contradictory "worlde", there could be no comfortable reconciliation between the extremes.

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[145] Bacon (ed.), Jane Cornwallis, Countess of Bedford to Jane Cornwallis (1 June 1620), 65-7.
[146] Loftis (ed.), Memoirs, 69; Clifford (ed.), Lady Anne Clifford, 178.
[147] Beier, Sufferers and Healers, 234-5.

Chapter Two

The Expertise of Women: Women and Medical Knowledge

Women's determination of their medical treatment was not only attained by their manipulation of stereotypes about women's health, but through the possession of a knowledge of medicine which was often equivalent to that of medical practitioners. During the early modern period, most people had a general knowledge of medicine; English society was a culture in which people familiarised themselves with their ailments and often treated the problem before calling a practitioner. As the primary health care providers for their families, servants, and neighbours, women provided numerous medical services from nursing to minor surgery. Women obtained their knowledge of medicine from several sources, both oral and printed. Within the culture of 'do it yourself' medicine, women were acknowledged as medical 'experts'--at least within the domestic realm. Women's medical knowledge and practice enabled them to supervise not only the health care of their families, but their own health care.

The activities of amateur women healers were the same as those provided by paid practitioners. Women prepared and administered medicines and remedies, delivered babies, did minor surgery, dressed wounds and applied leeches. Provided that women received no payment for such treatments, medical practitioners did not complain, except perhaps to accuse them of interference.[1] Indeed, medical practitioners often utilised medical recipes provided by women. For example, the physician John Symcotts was receptive to any remedy which had proven efficacious. He noted recipes from gentlewomen, whom he considered to be his equals in healing, such as the "spleen plaster of Lady Pickering" or "Mrs. Rolt of Perterhall's Medicine for the Ague."[2] In another case, Mistress Cosens suffered from severe bleeding during her seventh month of pregnancy. When his treatments failed, he took the advice of a 'beggar woman' who

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[1] Beier, Sufferers and Healers, 217.

[2] Ibid., 106-107.

"told the patient that she would recover if she took shepherd's purse in her broth." The treatment worked so well that he later prescribed it for a girl with excessive menstrual flow.[3] The 'professional' respect accorded to women by medical practitioners indicates the high status of women's role in the healing arts. In early modern England, the practice of 'kitchen physic' was considered part of a woman's proper education; a deficiency in medical knowledge, at least for gentlewomen, would be like not knowing how to bake.[4] Agreeing with many other household guide compilers, Gervase Markham wrote in his forward: "it is meet that shee [the housewife] haue a phisicall kinde of knowledge" in order to care for her family.[5]

Lucinda Beier has discussed how one's experiences of ill health were in part affected by gender insofar as women were expected to have an inherent talent for healing and nurturing. In contrast, men's roles usually took them beyond the medical sphere. Men tended to offer advice only when they either had a personal experience or interest in the ailment, whereas women were expected to have a broad knowledge of medicine.[6] Lady Anne Halkett is one of the few women who described the meaning of healing to her life. She perceived her assistance as both a "diverttisment" from her own problems and, by observing how others dealt with their suffering, "a helpe to instruct [her] how to submit under [her] owne crosses" to God's will.[7] Just as illness and pain were most often seen as God's chastisement for some moral crime, healing could teach submission to God's will. In a study of the 'mental world' of Stuart women, Sara Mendelson has pointed out that women, primarily through their roles as healers and care-takers, were in close contact with the "depressing *minutiae*" of life.[8] Mary Rich, Countess of Warwick, for example, was the medical practitioner not only for her large household, but for the poor. Mendelson has suggested that Mary, because of her role, keenly felt the insecurity of life. Even observing childbirth could be a distressing activity, eliciting a woman's own terror of the experience; at the lying-in of Lady Barrington in 1667, Mary was so afraid for her friend that she wept and prayed for a safe delivery.[9] Since women were thought to be prone to illness because of their own bodies, and were expected to be healers within the household, the relationship between the early modern meanings of illness and health care could be integral to a woman's understanding of her life.

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[3] Ibid., 112.

[4] Porter and Porter, Patient's Progress, 35.

[5] Markham, Countrey Contentments, 4.

[6] Beier, Sufferers and Healers, 241; Porter and Porter, Patient's Progress, 35.

[7] Loftis (ed.), Memoires, 58.

[8] Sara Mendelson, The Mental World of Stuart Women: Three Studies (Brighton, Sussex: The Harvester Press Limited, 1987), 99.

The activities of Lady Anne Halkett demonstrate the possible roles of a woman well-trained in the healing arts. In her memoires, Lady Halkett described her more remarkable cases. In September 1650, Lady Halkett was travelling to Scotland. On the way to Kinrose, she encountered two Royalist soldiers who had fought at Dunbar in need of medical attention for themselves and others. She gave them direction to the place where she would be staying, where she would provide help. The following day, twenty soldiers arrived; Anne estimated that she, her maid, and a man ('Ar.R.'), treated at least threescore over the subsequent days.[10] Two cases that she treated at this time illustrate her skill. One man had a "very dangerous" head wound right through the skull, at seeing which 'Ar.R.' exclaimed, "thou art butt a dead man."[11] Another man had been run through his shoulder, into his chest, with a bayonet; although he was not in pain, he was followed by a swarm of insects. After treating him, she gave him new clothes and burned the old ones.[12] Practicality was often the best method of treatment. Since few of the soldiers had received any medical treatment before coming to her, many of their wounds "were very noisome." In particular, one man with a bullet through the arm, smelled so bad that "none [but her] was able to stay in the room."[13] Not only skill, but a strong stomach was necessary to be a good healer. That so many soldiers had not received treatment from any practitioner and had to rely on Anne's medical mercy, raises the possibility that women may have played an important medical role during the Civil War period. Once she arrived at Fyfe, Lady Halkett's healing activities continued among civilians. To repay the hospitality of Lord and Lady Dunfermiline, she provided "helpe of the sicke and wounded persons."[14] Again, Anne emphasised her unusual cases. She treated Isabelle Stevenson who had suffered for three years "under a discomposed spiritt"; a young, previously beautiful, woman whose face was half-eaten away by cancer; and a man who had a four to five inch horn on the back of his head.[15] Lady Halkett's activities demonstrate both the extent to which women could develop their healing skills and the ways in which such skills might be used.

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[9] Ibid., 99-100.

[10] Loftis (ed.), Memoires, 55.

[11] Ibid., 55.

[12] Ibid., 55.

[13] Ibid., 55.

In her diary (1599-1605), Lady Margaret Hoby also kept a record of her healing activities within her own local area. The master or mistress of a household was frequently responsible for treating servants, employees, or villagers. This was often due to the distance and expense of paid practitioners.[16] As with Lady Halkett, it is difficult to determine whether Lady Hoby's activities were either more extensive or expert than other women. Nonetheless, like Lady Halkett, Lady Hoby perceived her healing skills as an important duty.[17] Although Lady Hoby did not describe in detail what sort of ailments she treated and how she did so, her diary does indicate that she frequently provided medical assistance for a variety of problems. For example, between January and April 1600, she reported "dressing" patients on 32 days.[18] She did not record how many she treated, but she often indicated that she treated more than one person by writing in the plural. On 2 and 3 February 1600, she "dressed the sores that came to [her]"; more frequently, she referred to "patients".[19] She mentioned treating wounds more often than any other problem. On 30 January 1600, she dressed a servant's cut on the hand and a man's injured hand, while a couple of days later she tended to a boy's leg.[20] In April 1601, she cared for Mr. Blakeborn's leg and foot which he had injured with a hatchet.[21] Lady Hoby's medical services also extended to surgery. A child who had been born without an anus was brought to her from Silpho on 26 August 1601. She was "ernstly intreated to

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[14] Ibid., 58.
[15] Ibid., 58.
[16] Porter and Porter, Patient's Progress, 25, 41.
[17] Beier, Sufferers and Healers, 223.
[18] Lady Hoby's Dairy 1599-1605, BL Egerton 2614 (Farnb.).
[19] Ibid., 48-55.
[20] Ibid., 48.
[21] Ibid., 149-150

Cutt the place to see if any passage could be made"; despite her efforts at cutting "deep", she was unable to find a passage.[22] Other activities were more mundane. Lady Hoby made an oil and purgation for her "cousin Ison's woman", a salve for a sore breast, and another salve for a sore arm.[23] Another activity that would have been common for women was attendance at a childbirth. In late November 1601, she was sent for by her cousin Bonchier's wife. Likewise, another cousin sent for her in February 1601/2.[24] A final aspect of her 'practice' was to provide advice and to share medical information. On 27 April 1601, she "talked with others that came to aske [her] connsill" and "gave some hearbes into a good wiffe of Erdey for [her] garden."[25] Although Lady Hoby may have been more active medically than other women of the same social status, her diary shows that she was a respected practitioner within her area and that she had a solid medical background.

While few sources written by women emphasise women's healing activities as much as Lady Halkett and Lady Hoby describe their own, several sources reveal that Anne and Margaret were not alone among women in having a broad medical knowledge and practice. The collection of letters addressed to Lady Joan Barrington (1628-1632) indicate that her medical advice and remedies were often sought by family members and friends. Sir William Masham wrote to her to request "some of [his] sister Everard's water for the eyes" and instructions on how to apply it.[26] Her daughter asked about curing a child's "swelling falen into the codds cleere like a bladder of water", remembering how Joan had cured another child of such a problem; her daughter recommended that the child be taken to see Joan.[27] Lady Margaret Oxinden was likewise often asked for medical assistance. In February 1640, she sent her nephew's wife, Anne, "a water for the wind" which she had found useful and instructed that it be taken with sugar and water. She also sent a powder to be taken in "a litel beer or posit" and further recommended that the patient take hot water.[28] In August, when Anne was severely ill again, Margaret recognised that her niece was beyond "the powr of any phisitian to alter", but sent several remedies to ease her pain. There was an ointment for Anne's forehead, a cordial to "procure rest", and a tisane (to be sent the next day) to help the cough.[29] References to women treating their immediate families are more common. Lady Brilliana Harley repeatedly sent advice and remedies to her son, Edward, while he was at Oxford. For example, in November 1638, she sent him licorice juice for a cold; the following spring, she sent him eye drops to help his sore eyes and preserve sight.[30] She often suggested that Edward use exercise for his health.[31] Similarly, during a temporary separation, Joan Thynne sent her husband and children a bottle of horehound, thinking "it will not be amiss ... this winter."[32] During another separation, Joan sent her husband medicine for his eye and suggested that he take physic as soon as possible.[33] Women's remedies and medical knowledge were requested by both men and women within their families for a variety of problems, showing the respect accorded to them for their expertise and experience.

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[22] Ibid., 173.
[23] Beier, Sufferers and Healers, 223.
[24] Lady Hoby's Diary 1599-1605, 185, 189.
[25] Ibid., 150.
[26] Searle (ed.), Barrington Family Letters, Sir William Masham (17 April 1632), 232.
[27] Ibid., Sir Gilbert Gerard to Lady Joan Barrington (20 June 1631), 196.

Treating their families from a distance would have been an extension of women's roles within the household. Ralph Josselin described his wife Jane's healing activities at home. In his diary (1640-1680), Ralph Josselin documented many of his family members' ailments and how the problems were treated. While Jane does not appear to have been as 'expert' as Lady Halkett or Lady Hoby, her medical skills were necessary for her family; perhaps her healing role within the household was more typical of early modern women. Ralph often includes himself as 'treating' his family, such as when his daughter Jane was ill of the spleen, he wrote that "wee applied an ointment to it, and a plaister."[34] Despite his participation, most of the medical duties fell to Jane. The treatments in this case, an ointment of melitot and three spoonfuls of clarified red fennel juice mixed with beer, would likely have been prepared by Jane Josselin. On another occasion, Ralph had mentioned that Jane had prepared a cough syrup for him.[35] The responsibility of nursing was also Jane's. At the end of 1649, the baby Ralph was ill and required constant care. Jane, who was "endur[ing] much toyle with him" in December, was "sickely with toiling with him" at the end of January.[36] Ralph also noted his wife's assistance with applying ointment to his ulcerated navel, pulling out a thorn which had been in his finger for six weeks, and tending to his swollen leg.[37] Another time, Jane stayed with the neighbouring Lady Honywood to help her with her sick child.[38] The Josselins seldom received medical assistance from outside the home. Ralph only made regular use of practitioners in the late 1670s when the pain of his ulcerated leg had increased almost to the point of lameness.[39] Lady Honywood's advice was occasionally sought, such as when Ralph and Jane were concerned about baby Ralph because they thought that he had rickets. When Jane took the baby to Lady Honywood for advice, Lady Honywood diagnosed the problem as consumption and suggested that they try an issue on the baby's skin. In this case, it is apparent that the final decision about treatment rested with Jane rather than her husband, as Ralph was thankful that his wife disregarded Lady Honywood's recommendation, instead using 'means'.[40] The importance of Jane's nursing skills to her family most clearly emerges through Ralph's expression of bewilderment when Jane, "on some discontent", refused to help him dress his leg.[41] Jane, like other early modern women, was ultimately responsible for her family's health care; she made remedies, nursed the ill, and sought further advice when she determined it to be necessary.

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[28] Dorothy Gardiner (ed.), The Oxinden Letters 1607-1642 (London: Constable & Co. Ltd., 1933). Margaret, Lady Oxinden of Deane to Henry Oxinden (14 February 1640), 191-192.
[29] Ibid., Margaret, Lady Oxinden of Deane to Henry Oxinden (n.d. August 1640), 179.
[30] Lewis (ed.), Brilliana Harley, Lady Brilliana Harley to Edward Harley (16 November 1638), 9; same to same (29 March 1639), 36-37.
[31] Cf. Ibid., Lady Brilliana Harley to Edward Harley (4 December 1638), 16-17.
[32] Wall (ed.), Two Elizabethan Women, Joan Thynne to John Thynne (3 October 1598), 12-13.
[33] Ibid., Joan Thynne to John Thynne (5 March 1602/3), 29-30.
[34] Alan Macfarlane (ed.), Diary of Ralph Josselin, 27 June 1652, 281.

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[35] Ibid., 13 October 1650, 218.

[36] Ibid., 30 December 1649, 186; 30 January 27 1649/50, 189.

[37] Ibid., 28 October 1648, 142; 10 April 1659, 443; 25 April 1675, 584.

[38] Ibid., 19 August 1648, 131.

[39] Ibid. There are only two references to the Josselin children receiving help from practitioners. Once a physician provided a syrup of roses to their baby suffering from congested lungs (17 February 1647/8, 112), but the physician had actually been in attendance for Ralph. In 1660, Mrs. Withers came to set their daughter's disjointed arm and splint Jane's instep (22 August 1660, 468).

[40] Ibid., 20 December 1649, 186.

[41] Ibid., 16 November 1676, 595.

All of these women whom I have discussed exhibited a wide medical knowledge, such as the ability to diagnose, to make and to administer remedies, and to practice surgery in varying degrees. Few historians, however, have examined from where women derived their knowledge or what the sources of women's knowledge might indicate. Primarily, medical knowledge was transmitted orally. Although evidence for the networks through which oral medical knowledge was transmitted can be traced, the type of knowledge exchanged is difficult for historians to retrieve. Literate women could also gain an understanding of medicine from books. During the seventeenth century, the printing of commonplace books, almanacs, and household guides, as well as midwifery manuals and medical treatises, ensured that printed medical knowledge was increasingly accessible to literate women. One genre in particular--the household guide--illustrates not only the printed health care knowledge available to women, but allows a glimpse into the oral medical lore. An analysis of household guides reveals three aspects of women's medical knowledge: the household guides reflected oral medical knowledge, printed medical knowledge was becoming readily accessible for literate women and their households, and the medical knowledge of the guides paralleled that of 'professional' practitioners. The possession of a strong knowledge in medicine ensured that women maintained control over their own health care; they often knew as well as the paid practitioners what course of treatment to take and what results they wanted.

In order to understand how household guides were an interface between oral and literate culture, it is necessary to examine the importance of an oral culture to women's health care; the oral exhange of information provided the most extensive opportunity for women to obtain medical knowledge. Several historians have discussed the existence of a female culture within the dominant society.[42] Sara Mendelson acknowledges that it is difficult to posit a women's culture that cut across social status in the highly stratified society of seventeenth-century

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[42] Sandra Cavallo and Simona Cerutti, "Female Honor and Social Control of Reproduction between 1600 and 1800", 73-109 in Sex and Gender in Historical Perspective eds. E. Muir and G. Ruggiero (Baltimore: Johns Hopkins University Press, 1990) trans. Mary Gallucci; Wendy Harding, "Medieval Women's Unwritten Discourse on Motherhood: A Reading of Two Fifteenth-Century Texts", Women's Studies 21 (1992), 197-209; Mendelson, Mental World of Stuart Women; Wilson, "Ceremony of Childbirth".

England. However, the suggestion of a shared female experience need not minimize the social and economic differences between women; while social class defined some aspects of women's lives, other areas were determined by gender.[43] Adrian Wilson argues that a network of 'gossips' linked the women within a locale together, partly mirroring the male hierarchy. Wider networks formed with the continual migration, giving the female culture a national character. Wilson suggests that in some respects, this culture may have been of greater significance than social status for the majority of women.[44] At the very least, women possessed a common knowledge of housewifery and the tasks of childbearing and childrearing.[45] Wilson and Wendy Harding see childbirth rituals as the main shared experience for a "collective culture of women".[46] Childbirth provided frequent opportunities for groups of women to meet. The expanding meanings of the term 'gossip' during this period could reflect the growing range of female activities to which childbirth was central.[47] That socialization was an important part of childbirth can be found in numerous contemporary sources. Margaret Cavendish complained that "there must be Gossiping, not only with Costly Banquets at the Christening and Churching, but they have Gossiping all the time of their Lying-in."[48] Samuel Pepys described a Christening party at which the men were "with the women above in her chamber," unsure whether they had "carried [them]selves well or ill."[49] The men, in this case, had entered a clearly female realm in which they felt uncomfortable. At another Christening, the men and women stayed in separate chambers.[50] At a gossips' dinner, Pepys was the only man to rise with the women; he took advantage of their collective expertise to ask for advice on begetting children.[51] Funerals as well could serve as a gathering for women, who were responsible for preparing the body for burial. Again, Pepys mentioned that men and women remained in separate rooms.[52] Childbirth and death certainly provided ample opportunity for women to exchange information in their groups.

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[43] Mendelson, Mental World, 6-7.

[44] Wilson, "Ceremony of Childbirth", 96-97. Wilson's assertion is a little extreme and needs qualification.

[45] Mendelson, Mental World, 8-9.

[46] Wilson, "Ceremony of Childbirth", 96; Harding, "Medieval Women's", 200. The term is Wilson's.

[47] Gossip originally meant "God sib[ling]". Wilson, "Ceremony of Childbirth", 97.

[48] As quoted. Mendelson, Mental World, 25.

[49] Latham and Matthews (eds.), Diary of Samuel Pepys, 29 May 1661, 109.

[50] Ibid., 19 November 1661, 216.

[51] Ibid., 26 July 1664, 222.

Such a collective culture held social ramifications for women. A woman's struggles became more effective when she had collective support behind her. An individual woman might not triumph over her husband, but with the social censure of women in the village against her husband, a woman might receive what she wanted.[53] Sandra Cavallo and Simona Cerutti have studied the brief glimpses available to a historian of a woman's network in early modern Italy. By confiding in her neighbours about her husband's behaviour, a woman could place her husband's actions within the public realm, ensuring that gossip would be used against him. Alliances between women were seldom explicit, expressed instead in secret forms of solidarity. Most often they were found in family relationships, especially between mothers and daughters.[54] The female networks are seldom obvious, primarily because they remained within the oral/unwritten sphere. However, a similar network of written health advice which appears to be an extension of an oral culture can be found in women's letters to other women, further reinforcing the theory of a culture of women. For Margaret, Countess of Panmure, female family and friends were her primary source of information and advice in her unsuccessful quest to conceive. Over a period of twenty years, Lady Belhaven, the Countess of Argyll, Lady Ranelagh, the Countess of Cassillis, Lady Lauderdale, and several midwives wrote letters of advice, provided recipes and magical stones, and sent remedies.[55] Lady Belhaven even gave sexual advice, suggesting that the Earl of Panmure anoint his penis with civet before intercourse. She also worried about the countess becoming worn out through too many miscarriages and urged the Duchess of Hamilton to suggest chastity to her son-in-law. In advising this action, Lady Belhaven recounted a story which further demonstrates a woman's network in action. In the 1630s, the Duchess's own aunt, Lady Crawford, had a similar problem. The physician in this case, Dr. Arnott, had Lady Crawford's mother talk confidentially to her son-in-law, warning him that his wife's life would be endangered if she conceived too soon.[56] A collective culture of women is most apparent within the realm of medical advice and childbirth.

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[52] Ibid., 18 March 1663/4, 90.

[53] Wilson, "Ceremony of Childbirth", 96.

[54] Cavallo and Cerutti, "Female Honor", 88-89.

[55] Marshall, "Treatment of Miscarriage", 32-35.

The defining factor of a women's separate culture was its oral nature. Although the ideal of womanhood was considered to be silence, women in reality were known for being more talkative. Women's discourse helped to bind villages together, aiding in the exchange of goods and services, or neighbourliness; gossip, in turn, was a form of social control.[57] On the one hand, women's words tended to be disregarded by men as merely gossip, but on the other hand, the power of the spoken word remained especially strong in an oral culture.[58] This meant that women who were unruly in their speech presented a threat to society.[59] As such, women often concealed the meanings of their speech. Sara Mendelson considers seventeenth-century women to have been a 'muted group'. As a result of their subordinate status, women were less able and less likely to express their own views in ways that an outsider could interpret. Moreover, women might pay lip-service to conventions, while circumventing those conventions in an indirect manner.[60] Potentially subversive behaviour or thoughts would have been expressed verbally. Wendy Harding suggests that, for the late Middle Ages, women were reluctant to write about subjects such as pregnancy, childbearing, female maladies, and birth control/abortion. When women did discuss pregnancy, they did so in different terms than men, using euphemism and allusion; thus, their bodies continued to remain 'unwritten'. Margaret Paston wrote of her pregnancy to her husband that she was "wax so fetis", representing her pregnancy as something which did not need to be written, being inscribed in her very flesh. Pregnancy belonged to a private, female sphere, rather than the public one in which the letters existed.[61] Harding suggests that women exerted control over their bodies by maintaining an oral channel of communication for female-related subjects, such as birth control, abortion, and gyneacological problems. Once a subject was written, it became available to the dominant culture for examination.[62] Mary Chamberlain discusses how medical recipes were passed orally among family members. If the recipes worked well, they would be used again. Other groups with common interests also transmitted information, just as women would about abortion and contraception. In such a case, oral transmission would have been necessary to ensure secrecy, the information only being passed to a trusted person.[63] Similarly, within society, women were known as the storytellers. In the early nineteenth century, John Clare reminisced about the story-telling of the old women who worked at weeding and bird-scaring with the children who were too young for regular field labour; "The old women's memories never failed of tales" he wrote.[64] An oral culture, for illiterate women, continued well into this century. The oral transmission was not limited to stories. Medical society as a whole depended upon oral communication; personal recommendation was more important than the printed word.[65] Within the sharing of women's medical knowledge, oral transmission would have been the primary means of dissemination.

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[56] Ibid., 36.

[57] Mendelson, Mental World, 4.

[58] Laura Gowing, "Gender and the Language of Insult in Early Modern London", 1-21 in History Workshop Journal 35 (1993), 5.

[59] For women, there was a fine line between acceptable speech and being outspoken. During the early modern period, scolding and causing public discord became a serious crime for women, punishable by the cucking-stool or scold's bridle. A reputation for scolding or cursing could lead to a woman being labelled as a witch. See Anne Llewellyn Barstow, Witchcraze: A New History of the European Witch Hunts (London: Pandora, 1994), 28; Keith Thomas, Religion and the Decline of Magic (N.Y.: Charles Scribners' Sons, 1971), 507; Christina Larner, "Witchcraft Past and Present", 79-92 in her Witchcraft and Religion: The Politics of Popular Belief ed. Alan Macfarlane (Oxford and N.Y.: Basil Blackwell, 1984), 84-85.

[60] Mendelson, Mental World, 4, 10-11.

Although English society remained an oral culture, there were literate women during the seventeenth century. In a study of literacy and popular books in seventeenth-

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[61] Harding, "Unwritten Discourse", 200-201, 203.

[62] Ibid., 201.

[63] Chamberlain, Old Wives' Tales, 178-179.

[64] Spufford, Small Books and Pleasant Histories (London: Methuen & Co. Ltd., 1981), 4.

[65] Paul Slack, "Mirrors of Health and Treasures of Poor Men: the Uses of the Vernacular Medical Literature in Tudor England", 237-275 in Health, Medicine and Mortality in the Sixteenth Century ed. Charles Webster (Cambridge: Cambridge University Press, 1979), 257.

century England, Margaret Spufford notes that the ability to read was tied to social status. To spare a child above the age of six or seven from working to attend school required prosperity. Education at grammar schools and universities was even more restricted by both the duration of the studies and the cost.[66] The question of literacy among women is difficult to determine. While women's literacy rates appear low, Spufford points out that the inability to write did not necessarily mean that the woman was unable to read. A study of literacy in the nineteenth century showed that those who could sign their names could read fluently; however, three-quarters of women who only made marks could also read. From the sixteenth to eighteenth centuries, school curricula generally omitted writing for girls.[67] There are also surprising examples of women of various social classes who could read. The Bishop of Stafforshire undertook a survey of his lands at Eccleshall in the 1690s. For a population of about 615 families, there were five female schoolteachers. Their ability to teach reading was implied by the Bishop's notation of a 'writing master' who came twice a year. 'Stephen Dimock's wife' and 'Thomas Alsop's wife' were married to day-labourers; 'Barnet's wife' was married to a shoemaker; and 'Curly Wollam's wife' was married to a labourer who thrashed, thatched, and wove.[68] Women from several segments of society may have had a greater ability to read than has previously been assumed.

Nonetheless, the seventeenth century was a period of 'interface' between the oral and printed culture. The process of reading itself occurred within the oral culture. Books were highly valued and respected, read and re-read, and meditated upon.[69] Indeed, printed material was disseminated through the process of reading aloud. Lady Hoby often mentioned reading with her friends and, on one occasion, to her 'women'.[70] Early modern people read their books with different methods than today. Roger Chartier has studied cheap, popular editions of early modern books and concluded that non-scholars had a disjunctive style of reading. Such readers used a method characterised by self-contained sequences.[71] Mary Fissell has used this theory to analyse some of the peculiarities of the most-published almanac, the Erra Pater, and chapbooks. Although chapbooks were short (about 24 pages), they were divided into chapters of 'free-floating' incidents. Repetition, also a common technique, is significant structurally for Erra Pater.[72] A study by David Cressy of an eighteenth-century orphanage indicates that girls were less fluent readers. If this pattern were widespread, women may have tended toward a discontinuous style of reading.[73]

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[66] Referring to the ability to sign one's name as an indicator of literacy, between 1580-1700 in East Anglia. only fifteen percent of labourers could sign, while fifty-six percent of tradesmen/craftsmen and sixty-five percent of yeoman could sign. . Women appeared to be even less literate; only eleven percent signed their names. The only evidence of literacy for a broader cross-section of all of English society for this period is the Protestation Returns of 1642, as these were to have been signed by all adult males. The Returns show that throughout the countryside, comparing parishes, between fifty-three to seventy-nine percent (with an average of seventy percent) of men were unable to sign their names. Taken more positively, even in the least advanced parishes, at least twenty percent of men could sign their names. Spufford, Small Books, 9, 21-22.

[67] Ibid., 22, 34. The typical school curricula taught boys how to read, write and account, while girls learned how to read, sew, knit and spin--skills that cannot be measured.

[68] Ibid., 36.

[69] Mary Fissell, "Readers, Texts, and Contexts: Vernacular Medical Works in Early Modern England", 72-96 in The Popularization of Medicine 1650-1850 ed. Roy Porter (London and N.Y.: Routledge, 1992), 77.

Such reading techniques were functional, and can help to explain the structure of books intended for women. Jane Sharp's The Midwives Book contains extensive repetition of ideas. In one instance, Jane Sharp discussed the process of menstruation in chapters on 'false conceptions', monstrous births, and menstruation; at the same time, she also reiterates the idea of problematic conceptions occurring as a result of intercourse during menstruation in the first two of these chapters.[74] This pattern would have made the book a handy reference manual in which the reader could look up the pertinent chapter and have all of the information, without a need to cross-reference. Domestic manuals were similarly structured, in that the subjects were divided into short chapters. In A Closet for Ladies and Gentlewomen, the index listed the subjects of preserves, candying, pastes, banqueting-conceits, cordials, conserves, and medicines and salves.[75] Within the chapters, recipes tended to be grouped according to ailment, albeit somewhat haphazardly. Recipes for food items might be included between medicines and there was no formal structure in organisation. The compiler of A Closet for Ladies and Gentlewomen placed a recipe for cheese between two treatments for ague and began the chapter with women's ailments, followed by a cure for a tetter.[76] The subjects of the recipes were quite clear, however, and the recipes were generally divided into separate paragraphs. Possibly, the owner of such a domestic guide would have known specifically which recipe she wanted and scanned the book accordingly. The oral nature of reading would have further disseminated the ideas contained in printed books, while women's style of reading was one of practicality rather than entertainment.

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[70] Cf. Diary of Lady Hoby, 1 September 1599, 10; she frequently mentioned Mr. Rhodes reading to her. She also read to her women, as on 19 May 1600, 75.

[71] Argument cited by Fissell, "Reader, Text, and Context", 77.

[72] Ibid., 78.

[73] Argument as cited. Ibid., 88.

[74] Sharp, Midwives Book, Book II Chapter 4, 106-116; II.5, 116-124; V.9, 288-296.

[75] Anon. A Closet for Ladies and Gentlewomen (London: Printed by R.H., 1656).

At this time, moreover, popular texts were often a form of oral culture being written down. Thus, medical materials printed for a popular audience in this period can be studied as remnants of the oral culture.[77] On the one hand, printed texts drew from the oral culture; yet, the process of writing the oral culture could ultimately undermine it. Oral lore for medicine might have been preserved in proverbs; several well-known proverbs date from at least the seventeenth century.[78] While folklorists of the seventeenth century recorded the popular beliefs to illustrate the folly and irrationality of the lower classes, they did not record the oral culture of the educated classes, who also spoke frequently on the subject of medicine. Nonetheless, the gap between the oral culture of the educated and the illiterate may not have been that great; both groups used magical remedies, for instance.[79] Collections of medical remedies, to some extent, reflected the pluralism of the medical culture, repeating and legitimizing the cures of popular medicine.[80] Printed collections of medical recipes further contributed to the oral exchange of information. In addition to providing information to treat one's own family, such books aided women, especially upper class, in treating the poor and in providing medical advice.[81] Medical collections covered familiar subjects, probably one reason for their success. Paul Slack writes that the authors and publishers attempted to cater to the requirements of their readership.[82] The contents of the books further mirrored oral culture. To early modern people, words had magical potential. In Erra Pater, words sometimes took on quasi-magical properties. Erra Pater recommended several methods of divination which relied on the manipulation of the letters of a person's name or required the person's Latin name.[83] Spells could also be used for healing. Mary Chamberlain lists a number of medical spells, such as one for St. Vitus' dance.

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[76] Ibid., 36-37; 30-31.

[77] For instance, a study of English folk-song revivals by Robert Thompson demonstrates the importance of the contact between increasing literacy and an oral culture. Ballad broadsides were printed in increasing numbers as the demand for printed materials grew. In early twentieth-century folk song collections, at least eighty percent of the songs were derived from printed broadsides, several of which can be dated to broadsides printed before 1700. Spufford, Small Books, 9.

[78] Porter and Porter, Patient's Progress, 192. While a study of proverbs and medicine has been done for France, Loux and Richard, Sagesses du Corps, a similar study for England has not been undertaken.

[79] Roy and Dorothy Porter, Patient's Progress, 192.

[80] Slack, "Vernacular Medical Literature", 266.

> Shake her, good Devil
> Shake her once well;
> Then shake her no more
> Till you shake her in hell.[84]

In addition to amulets or crucifixes, people wore written messages of charms or prayers to prevent disease.[85] The medical recipe collections of the seventeenth century reflected the oral culture; such books were written for a broad non-practitioner audience, covered subjects already familiar to people through popular culture, and emphasised the power of words.

During the seventeenth century, printed medical texts became readily available for the reading consumer. Several types of early modern books contained medical information. Paul Slack has examined the number of medical books published during the late sixteenth century. In his statistics, however, he only includes medical treatises, usually written on specific ailments, and general physic books. Overall, these medical works composed a small part, about three percent, of the total books published for the Tudor period.[86] While such a small number would not have made a substantial impact on the reading public, medical books appeared in large enough numbers to have been available to those who wanted them. After 1575, the number of new medical works exceeded the number of reissues; in the 1650s, the number of new publications rose dramatically.[87] In these numbers of medical publications, Slack has omitted almanacs and domestic guides, which also contained medical information

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[81] Ibid., 260.
[82] Ibid., 252.
[83] Fissell, "Readers, Text, and Context", 76.
[84] Chamberlain, Old Wives' Tales, 164.
[85] Ibid., 166.
[86] Slack, "Vernacular Medical Literature", 239.

Almanacs were more popular than any other type of medical publication. Over 600 different almanacs had been published by 1600.[88] Likewise, from the 1660s through the 1680s, the Erra Pater, an almanac that contained medical and astrological information and a calendar, sold over 400,000 copies in some years.[89] Moreover, almanacs were cheap, costing only a few pence. By the end of the Tudor period, almanacs had become commonplace, the only secular literature to be encountered by most of the population.[90] General remedy collections were another type of literature more readily available to a general readership, and based on the older tradition of manuscript recipe collections. These books varied widely in the quality of their contents, but most simply listed the illnesses, not necessarily alphabetically, with one or two remedies. Such collections were practical, intended for daily use. The suggested remedies tended to be purgatives or soothing concoctions.[91] Another common type of book, related to medical knowledge, was the herbal. Herbals contained information on the planting and growing of herbs, astrological lore regarding when herbs were best collected and used, and in what ways medicinal herbs were related to various astrological signs and influences. To some extent, this demonstrates the existence of a prevalent symbolism that was familiar to most people. Nicholas Culpeper ultimately synthesised such widely diffused ideas in his English Physician, wherein he stressed the rationale of astrology.[92] In addition to the directions for growing and collecting herbs, herbals also listed the medical and detrimental properties of plants. Nonetheless, the author of an herbal might include a cautionary note, or disclaimer, about the limited medical information of the herbal. "I referre to Herbals for we are Gardiners, not Physicians."[93] A final genre of literature most relevant to women and their practice of medicine would have been domestic guides; medical recipes generally composed at least half of such guides.[94] Of the types of medical literature, domestic guides, which included other domestic information, such as cosmetics, cookery, laundry, and animal husbandry, would have been the books most likely owned by women. For example, other vernacular medical literature was often written for a fairly 'learned' audience, despite claims to the contrary in prefaces. Since women had a low level of education, this may have excluded women from the audience. Only almanacs were available in large enough numbers to reach the lowest literate groups. Even almanacs, however, demanded a knowledge of dates and times, and assumed a choice of diet or exercise more common to the well-off. This is not to say that less well-off literate women did not own or have access to books, since simpler collections of remedies may have had a broader appeal.[95] A variety of medical information was becoming available to the literate consumer, both male and female, wealthy and less well-off.

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[87] Ibid., 239-241.
[88] Ibid., 256.
[89] Fissell, "Readers, Texts, and Contexts", 72.
[90] Allan Chapman, "Astrological Medicine", 276-300 in Health, Medicine and Mortality in the Sixteenth Century ed. Charles Webster (Cambridge: Cambridge University Press, 1979), 284; Fissell, "Readers, Texts, and Contexts", 75.
[91] Slack, "Vernacular Medical Literature", 250-251, 261.
[92] Chapman, "Astrological Medicine", 297-298.

Although upper class women would have had the greatest opportunities to obtain a broad range of medical books, poorer literate women and even illiterate women had opportunities to access the information contained in books. Even if a literate woman did not own her own medical book, she could borrow one. Lady Joan Barrington's daughter, Lady Anne Conway and Lady Margaret Hoby all made references to sharing or reading books of a medical nature.[96] Domestic guides, while most often intended for use in 'wealthy' households, were available to the servants. Margaret Spufford has examined the cookery books in Samuel Pepys' collection. Although not all of the cookery books were lavish, as implied by the ingredients in recipes, or the occasional use of the term 'gentlewomen' in the titles, Spufford concludes that many cookery books were aimed at the households of the gentry or mercantile families. Interestingly, the intended market was likely the domestic servants.[97] The actual audience of books such as domestic guides is hard to trace because so few exist today; household guides would have been used until they fell apart. It is possible that a family who could not afford the cookery or medical ingredients within the book might have kept the book as a reference guide, substituting alternate ingredients. A final way in which women may have accessed written medical information was through the oral transmission of its recipes. Ultimately, the audience for a household book, whether literate or oral, could have been broad; indeed, such books reflected, to a large extent, the oral culture from which the recipes and medical knowledge had been derived.

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[93] Gervase Markham, The Country Hovsewifes Garden (London: Printed for Roger Jackson, 1623), 11.

[94] Cf. A Closet for Ladies and Gentlewomen, pages 30-84 out of 84 pages; Treasure of Hidden Secrets (London: Printed by Richard Oulton), only the first 24 pages were on cookery and laundry, the remainder contained medical recipes.

[95] Slack, "Vernacular Medical Literature", 258.

[96] Barrington Letters, Sir Gilbert Gerard to Lady Joan Barrington (18 August 1628), 36; Conway Letters, Lady Anne Conway to her husband (16 September 1664), 230; Diary of Lady Hoby, 15 October 1599, 22.

The intent of household guides was clearly practical. The books had all of the information thought necessary for running a household. As the subtitle of Gervase Markham's Countrey Contentments claimed, the book contained "the inward and outward Vertues which ought to be in a compleate Woman." The list of a woman's knowledge included: skill in physic, surgery, making oils and banqueting 'stuffe', ordering great feasts, preserving wines, making conceits, distillations and perfumes, working wool, hemp and flax, making cloth and dying, knowledge of dairies, malting, and oats, brewing, baking and "all other things belonging to a Houshold."[98] Of these, medicine received the most attention in manuals, being considered one of the most useful domestic arts. Domestic guide books or simple remedy collections may even have begun to take the place of private recipe books. Linda Pollack has discussed how women wrote down recipes in private medical books because such knowledge was thought to be useful.[99] Moreover, as Paul Slack has argued, since publishers catered to the demands of their reading public, general medical recipe collections reveal the medical knowledge, assumptions, and concerns of their audiences.[100] The variety and quantity of domestic guides then suggests that readers considered the information in this genre to be particularly useful, perhaps, to some extent, in place of private recipe collections. Like collections of remedies, domestic guides would have been helpful tools for the literate, used primarily by women in caring for their families.[101] Such guides would not have dictated women's medical behaviour--as discussed in the previous chapter, women often manipulated general 'knowledge' or stereotypes. Rather, these guides simultaneously show what printed sources of medical knowledge contained and reflect the medical understanding of an oral culture. The majority of recipes in the guides are for what were considered to be 'common' ailments, those most likely to require immediate treatment or be treatable within the household. Although each of the household guides examined here emphasised different ailments, the difference was generally one of quantity rather than kind. For example, A Closet for Ladies and Gentlewomen had twenty recipes for headaches; Country Contentments had two; Widowes Treasure had one; but Hidden Secrets had none. In regards to other women's ailments, Hidden Secrets had the best selection of treatments, being a book primarily for women's diseases, while Widowes Treasure contained only three aids for women's problems. All, however, had recipes (among many others) for ague, plague, skin problems, worms, stings and bites, sores and cuts, jaundice, eye problems, toothaches, burns, rhumes and sore throats, staunching bleeding.[102] These treatments, despite their occasionally exotic ingredients, had a practical purpose. A comparison of medical recipes included in several household manuals, midwifery manuals, and John Symcotts' case notes indicates that such recipes reflected common treatments and that there was not a significant difference between domestic and 'professional' treatments.[103]

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[97] Spufford, Small Books, 61.
[98] Markham, Countrey Contentments, title page.
[99] Pollack, "Experience of Pregnancy", 56.
[100] Slack, "Vernacular Medical Literature", 261.

Like medical commonplace books, domestic manuals contained conventional and conservative medical knowledge. The information and remedies neither conflicted with traditional medical knowledge nor introduced innovative ideas.[104] Of the domestic manuals examined, only Treasure of Hidden Secrets discussed "the knowledge of the names and naturall disposition of divers diseases that most commonly happen to molest and grieve the bodies of men and women".[105] The other manuals merely presented the medical recipes without preamble. The presentation of medical knowledge of women's bodies illustrates the contemporary understanding of the body. In the chapter on the formation of the secundine, the author cited Gilbertus as the source.[106] The subject of another chapter is the relation between astrology and medical treatment, giving the best times to let blood or take a laxative.[107] Compared to admittedly later editions of two midwifery treatises, The Birth of Mankind and The Midwives Book, the medical knowledge is old-fashioned.[108] For example, the author of Treasure of Hidden Secrets described how the matrix has several pleats into which the male seed may fall, each creating a child. The Birth of Mankind and The Midwives Book argued against this older notion, referring to only one chamber in the uterus. As Jane Sharp wrote, "none that ever saw the womb can think so."[109] The author further justified writing on women's secrets in the traditional manner of the 'Secrets' genre, asking the reader not to "despise" the book's contents, "being the workes of God whereby ye may plainely undertaken how ye were brought into this world."[110] The domestic guides provided conventional concepts of medicine in a traditional manner.

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[101] Slack, "Vernacular Medical Literature", 260.

[102] Anon., A Closet for Ladies and Gentlewomen; Anon., The Widowes Treasure (London: Printed by R.B. fo Robert Bird, 1639); Anon., The Treasure of Hidden Secrets (London: Printed by Richard Oulton, 1637); Markham, Countrey Contentments.

[103] For the purposes of this section, I am considering the two midwifery treatises to contain 'professional' treatments.

[104] Slack, "Vernacular Medical Literature", 261.

The household guides did not reflect the increasing misogyny of elite medicine in either theory or in the suggested treatments. Instead, the authors of three of the domestic guides presented their contents in a morally neutral manner, not mentioning any theories of disease or workings of the body.[111] In contrast, the author of The Treasure of Hidden Secrets labelled menstruation as an "euill", the general term for an illness and called the afterbirth a "malady".[112] Within the framework of a society in which pregnancy was considered an illness by women themselves, however, such labels cannot be considered "misogynistic" by modern standards. Women, being products of their culture and their time period, did accept the prevalent male-oriented social concepts of their bodies to some extent. While Jane Sharp agreed that the uterus was responsible for all of women's physical ills, she also wrote that "we women have no more cause to be angry, or be ashamed of what Nature hath given us than men have."[113] Even the author of The Treasure of Hidden Secrets had insisted that the subjects of women's bodies and childbirth were not shameful.[114] Moreover, the suggested treatments were not any more brutal for women's diseases than any other ailment. The majority of treatments adhered to the standard courses of physic, which consisted of purgation, modified diets, and plasters. Hysteria, or "suffocation of the womb", was treated by fumigation or a medicinal drink.[115] For green sickness, Markham recommended that the young lady take exercise as well as one of two medicinal drinks; the author of The Widowes Treasure similarly suggested exercise, combined with a special diet of milk and spice soaked veal taken as a broth or jelly and a special toast for five or six weeks.[116] The most drastic of treatments was reserved for the most drastic of problems--inducing menstruation. The author of The Treasure of Hidden Secrets provided several options ranging from herbal drinks and suppositories, to a fumigation which, unusually, involved inserting the pipe "up into the Matrice" to open it.[117] The medical treatments for women's ailments suggested by the domestic manuals were essentially no different than the courses of treatment prescribed for other, non-gender-specific, medical problems.

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[105] The Treasure of Hidden Secrets (1637), Ch.59, D3.
[106] Ibid., Ch.59, D4.
[107] Ibid., Ch. 62, E1-E2.
[108] Thomas Raynald (trans.), The Birth of Mankind (London: J.L. Henry Hood, Abel Roper and Richard Tomlins, 1654); Sharp, The Midwives Book (1671).
[109] The Treasure of Hidden Secrets, D3-D4; The Birth of Mankind, Ch.6, 27; Sharp, The Midwives Book, I.Ch.17, 69.
[110] The Treasure of Hidden Secrets, Ch.59, D5.
[111] Closet for Ladies and Gentlewomen; The Widowes Treasure; Markham, Countrey Contentments.
[112] Ibid., Ch. 59, D3, D4.

The similarities between the contents and methods of medical treatments discussed in the domestic guides and by 'professional' practitioners are striking; such similarities demonstrate that women's and professional medical knowledge were closely related. For example, one method of inducing labour, fumigation, was suggested in the midwifery treatises, The Birth of Mankind and The Midwives Book, and in one domestic guide, The Treasure of Hidden Secrets.[118] Although the suggestion in Hidden Secrets, that the woman strike downwards on her stomach, seems non-medical, The Birth of Mankind suggested a similar activity, stroking the stomach.[119] To stop menstruation or miscarriage, the herbs of shepherd's purse and plantane, and the spice cinnamon were frequently used. The physician John Symcotts, upon the advice of a beggar woman, ordered a broth of plantane and shepherd's purse to stop Mistress Cosens' bleeding during her seventh month of pregnancy and later to Mistress Weaver to stop her copious menses.[120] The midwife Jane Sharp listed plantane as one herb to hinder abortion, and plantane and shepherd's purse to stop menses, while The Treasure of Hidden Secrets used plantane juice and shepherd's purse juice in different remedies to stop the menses.[121] Herbs recommended to induce menstruation were, not surprisingly, also abortifacients.[122] Several of these herbs (birthwort, motherwort, pennyroyal, fennel and savine being the most common) were mentioned in two guide books, The Widowes Treasure and The Treasure of Hidden Secrets and both midwifery manuals, The Birth of Mankind and The Midwives Book. The most frequent methods of taking an emmenagaogue were through suppository or fumigation; only a few recipes were to be taken as drinks.[123] Although The Birth of Mankind provided a list of effective herbs, no recipes were given and the reader was cautioned to "use none without the counsel of a physician."[124] To treat problems of lactation, poultices and plasters were used. While the herbal components varied, all of the recipes contained a base of bran, oatmeal, or bread crumbs, and oil or grease.[125] The types of treatments presented in the domestic guides and 'professional' guides illustrate the closeness between the knowledge available to women and the knowledge possessed by professional practitioners.

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[113] Sharp, The Midwives Book, I. Ch. X, 33.
[114] The Treasure of Hidden Secrets, Ch. 59, D5.
[115] Ibid., Ch.64, E2, Ch.67, E3.
[116] Markham, Countrey Contentments, 35; Widowes Treasure, E5.
[117] The Treasure of Hidden Secrets, Ch.66, E2.

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[118] Birth of Mankind, 109; Midwives Book, 218; Hidden Secrets, 71.

[119] Birth of Mankind, 109; Hidden Secrets, 71.

[120] F.N.L. Poynter and W.J. Bishop (eds.), A Seventeenth Century Doctor and His Patients: John Symcotts, 1592?-1662 (Streatley: Bedfordshire Historical Record Society, no.31, 1951), 55-56.

[121] Sharp, The Midwives Book, IV.225, V.298, 299 ; Hidden Secrets, Ch.72, 74.

[122] According to a list of abortifacients given by the astrologer-medical practitioner, Simon Forman in his treatise on diseases of the matrix reprinted in Traister, "Matrix", 446.

[123] Hidden Secrets, Ch.69; Sharp, Midwives Book, V.295.

[124] Birth of Mankind, 117-118.

[125] Closet for Ladies..., 33, 74; Hidden Secrets, Ch.94-97; Markham, Countrey Contentments, 36-38; Sharp, Midwives Book, VI.338-339, 350.

The medical treatments between the texts are similar in another way; several of the remedies were based on the concept of sympathetic healing. For trying to stop menses, a plaster from The Birth of Mankind contained red ingredients; pomegranate, amber, sanguis draconis, hematites, red rose, and red wine.[126] Red items would ensure that the blood remained inside the body.[127] Paradoxically, along this principle, red items were also used in remedies to stop the whites. Perhaps significantly, these remedies were taken as drinks rather than as a plaster. In ACloset for Ladies and Gentlewomen, one remedy called for the new milk of a red cow, red rose water, pomegranate seed, and cinnamon; in The Widowes Treasure, the remedy contained pomegranate flowers and red wine.[128] Jane Sharp also relied on a form of sympathetic healing for stopping women's fluxes. She noted that three types of fluxes, white, red, and yellow, existed in women; for these, three types of nettles existed. To cure the whites, white nettles should be rubbed on the patient's skin.[129] Likewise, the fumigations for prolapsed uteri and inducing labour or drawing out the secundine worked along the traditional concept of attraction and repulsion; just as the uterus would be drawn upwards by inhaled sweet smells or by foul-scented items held beneath the vagina, sweeter smells from beneath would draw out the unborn child or the secundine.[130] The parallels between the treatments of the domestic guides and those of practitioners indicate that the medical knowledge available to women was little different from that of medical practitioners. As illustrated by the medical remedies, the differences between amateur and professional healers, female and male practitioners, and popular and elite medicine were less pronounced than has often been thought.

Seventeenth-century English women maintained significant control over their own health care. Women's knowledge of medicine, drawn from the popular oral culture, as reflected in the domestic manuals, and from the increased number of medical books for the laity, was frequently equivalent to that of the 'professional' male practitioners or midwives. The domestic manuals indicate the substantial base of medical knowledge, both written and oral, available to women for the health care of their families and themselves. Within the realm of the home and local area, women were responsible for providing care to their family and friends. Their male counterparts, moreover, acknowledged women's medical expertise. As primary health care givers, women would have often understood as much about their own health, disease, and treatment as the practitioners. Even within the role of patient, women continued to have the final say over their own treatment; indeed, their medical knowledge would ensure that they were able to make 'educated' decisions about their own treatments.

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[126] Birth of Mankind, 122.

[127] By the principle of attraction in Galenic medicine, for example, white sheets might attract the red of the blood, thus promoting bleeding. Duden, Woman Beneath, 22.

[128] A Closet for Ladies and Gentlewomen, 32; Widowes Treasure, D6.

[129] Sharp, Midwives Book, 305.

[130] Hidden Secrets suggested a fumigation of burning goats' skin to induce labour, Ch. 71, which goes contrary to the usual concept of attraction; in contrast, and more usual, Jane Sharp referred to a fumigation of marigolds to draw out the secundine, Midwives Book, 218.

Chapter Three

Active 'Patients': Women's Sick Roles and Gendered Treatment

In calling for a patient-oriented medical history, Roy Porter pointed out that the term "'patient' seems dangerously redolent of professional medical relations."[1] Indeed, the word 'patient' implies a passive role. The sick role of seventeenth-century English women, however, was not passive; patienthood often provided opportunities for women to gain power over their own bodies. Several studies have examined the roles taken by sick people during the early modern period, but little work has been done specifically on women as patients in order to determine whether or not the experience of illness was affected by one's gender.[2] While women had the knowledge necessary to treat themselves medically, did women lose power over their own bodies once they had became patients, submitting themselves to the care of a medical practitioner or their family and friends?

Like all patients, women could determine their health care to some extent through their choice of practitioner. Medical practitioners were not considered infallible; patients could and did disagree with their healers. When the patient disagreed with a practitioner, she would seek another opinion. Medical practitioners recognised the need for 'customer service' and often conceded to their patients' expertise and opinions; if the 'customer' was dissatisfied with her treatment, there were several options open to her. Similarly, the culture of the sick room placed the patient in a position central to the lives of those around her: she required care, her household duties needed to be done by another, and neighbours visited her. Finally, a comparison of medical treatments for male and female specific problems shows that women were not treated according to the misogynistic theories of formal medicine.[2] Even within the role of patient, women maintained control over their own health care.

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[1] Roy Porter, "The Patient's View. Doing Medical History from Below". Theory and Society 14 (1985): 175-198, 181-2. I will, however, use the term 'patient' for lack of a better term.

[2] Beier, Sufferers and Healers and Porter and Porter, Patient's Progress each have a chapter on women as patients.

While not the only determinant, economic status was an important variable in the health care that women received since economics determined the dynamics of the patient-practitioner relationship. Early modern people of all classes would have used home remedies first. Depending on one's skill and the nature of the illness, self-treatment may have been all that was needed or desired. As previously discussed, patients also had recourse to family and neighbours. Even wealthy families might exhaust self-treatment possibilities before seeking professional assistance. Lady Brilliana Harley wrote that she was worried about her daughter Dorrity who had "bine exceeding ill" for about ten days, but remained "very unwilling to send for any docter, tell shee grue very ill . . . that [she] very much feared her."[3] For many sick people, medical care might only be that provided within the domestic realm. A woman's decision to seek further medical attention depended on several factors: her finances, her symptoms, and her expectations of the healer.[4]

Traditionally, medical historians have assumed that there were only a few licensed practitioners in seventeenth-century England and that these few served only the upper classes who could afford their services.[5] In part, this is true; certain 'top' practitioners specifically cultivated their practices among the wealthy.[6] More recent studies have demonstrated, however, that most practitioners did not necessarily treat only the rich or powerful. Margaret Pelling has examined the distribution of barber-surgeons throughout seventeenth-century London, for example, finding that they often had 'underworld' connections.[7] In their study of medical practitioners in sixteenth-century London and Norwich, Pelling and Charles Webster have shown the diversity of medical practitioners available for varying prices. In the parish of St. Botolph without Aldgate, the practitioners ranged from Richard Foster, a barber-surgeon and Nathaniel Thorey, a grocer, at the higher end of the fees scale, to Edward Askew "a poor man, professor of physic" and Margaret Mott, "a counterfeit physician, and surgeon . . . and old quacksalver", who would have commanded lower fees.[8] Even top physicians might treat the less affluent on a sliding scale.[9] Dr. John Symcotts (1592-1662), a rural physician, included among his patients Oliver Cromwell and his family members, several members of the nobility, local shopkeepers and merchants, and less affluent people, such as "the poor woman of Fenton" or "Widow King of Godmanchester".[10] The casebook of Joseph Binns (fl. 1633-1663), a respectable London surgeon, indicates that, of the patients whose socio-economic status can be determined, that there were 29 higher status, 181 middling status, 50 artisans, 71 servants, and 74 lower status.[11] Similar evidence exists from a study of a German barber-surgeon, Gerard Eichhorn, one of the top practitioners in seventeenth-century Cologne. Eichhorn's patients came from different social groups, but with a prevalence of artisans and soldiers.[12] In urban areas, hospitals and the individual charity care given by local practitioners offered further opportunities for health care for the very poor. Pelling and Webster have discussed the charitable medical assistance to the poor in sixteenth-century Norwich. Although most medical relief consisted of money, fuel and clothing to alleviate unhealthy conditions, the corporation of Norwich also hoped to prevent more costly diseases by paying minor officials to take the indigent sick into their houses. Boarding a patient in this way often entailed nursing care. Moreover, several of the better-known surgeons of the town, as well as apothecaries, bone-setters, and female practitioners, had contracts with the corporation for the cure of the poor.[13] While one's pocketbook did have a role in a patient's choice of practitioner, it was not the dominant factor, and even the poorest might receive treatment from 'important' practitioners.

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[3] Letters of Lady Brilliana Harley, Lady Brilliana Harley to Edward Harley (17 May 1642), 161.

[4] Beier, Sufferers and Healers, 54; Porter and Porter, Patient's Progress, 17.

[5] For example see A. Chaplin, Medicine in England during the Reign of George III (London: Henry Kimpton, 1919). Pelling and Webster argued specifically against the older viewpoint in "Medical Practitioners".

[6] Beier, Sufferers and Healers, 55; Porter and Porter, Patient's Progress, 17.

[7] Margaret Pelling, "Appearance and Reality: Barber-Surgeons, the Body and Disease", 82-112 in London 1500-1700: The Making of the Metropolis ed. A.L.Beier and Roger Finlay (London and New York: Longman, 1986), 84-89, 104.

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[8] Margaret Pelling and Charles Webster, "Medical Practitioners", 165-236 in Health, Medicine and Mortality in the Sixteenth Century ed. Charles Webster (Cambridge: Cambridge University Press, 1979), 186.

[9] Porter and Porter, Patient's Progress, 17.

[10] F.N.L. Poynter and W.J. Bishop, A Seventeenth Century Doctor and His Patients: John Symcotts, 1592?-1662 (Streatley: Publications of the Bedfordshire Historical Record Society vol. 23, 1951), xxi-xxiv. Of the 83 cases recorded in his casebook, 27 were upper status, 41 middling status, and 13 lower status. Beier, Sufferers and Healers, 112.

[11] Beier, Sufferers and Healers, 55. This was determined primarily by forms of address and titles.

[12] Robert Jutte, "A Seventeenth-Century German Barber-Surgeon", 184-198 in Medical History 33 (1989), 189-190.

The expectations that a patient had for the practitioner were often more important than financial reasons in the decision-making process. Personal preferences as to the 'style' of medicine or the problem being treated could determine the type of practitioner chosen. Beier notes that one's social background influenced the selected type of practitioner. Physicians, being well-educated, moved more comfortably in the 'high culture' of the wealthy, whereas surgeons were more like craftsmen. Moreover, the greatest difference between a physician and a surgeon was that the physician could both prescribe medicines for internal problems and provide a humoral explanation of the ailments; the people who wanted such explanations tended to be better educated themselves.[14] While Dr. John Symcotts had a predominance of higher status, potentially better-educated, patients, his prices could be 'cheap' in comparison to the surgeon Joseph Binns' fees. In 1641, while treating Mr. Powers, a coal merchant, over a two month period, Symcotts charged £1.2s.8d. Binns had primarily middle and lower class patients, but received £29.9s for providing home visits and constant treatment to one patient over a year.[15] Such prices were high, but the patients in these cases paid for extended services, rather than the short-term treatment generally sought; the choice of practitioner had less to do with economics than with the type of treatment offered. In contrast to Beier's opinion that social status was most significant, Robert Jutte suggests that one's social status and the selection of a practitioner were not closely correlated. For cases of serious injury or 'external' disease, for example, people may have had little choice but treatment from a barber-surgeon.[16] The two points of view do not necessarily contradict each other. Although a patient might select one type of practitioner more often, she might choose a different type of practitioner if the problem in question seemed to warrant different assistance. There was a variety of practitioners, many of whom may have appealed to different strata of society for social reasons or the type of treatment needed, rather than for economic reasons. Wise women or cunning men would be especially useful in dealing with a supernatural cause of illness, whereas a bone-setter would be an obvious choice for setting broken bones. These lower status practitioners may also have been able to set at ease people of their own social background better than 'higher' practitioners. Finally, individual practitioners often developed areas of specialty, which attracted more clients for the treatment of such problems. Of 520 patients treated by Binns, 300 were men; of these 300, one third suffered from syphilis or gonorrhoea.[17] Other practitioners treated a greater proportion of female patients. Simon Forman, the unlicensed astrologer-practitioner, specialised in treating women's ailments and melancholy.[18] In his treatment of mental disorders, Richard Napier also had a disproportionately large female clientele.[19] With so many types of practitioners in existence, personal preference--whether related to social expectations or the type of treatment required--played the greatest role in the selection of a healer.

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[13] Pelling and Webster, "Medical Practitioners", 217-218.
[14] Beier, Sufferers and Healers, 113.
[15] Beier, Sufferers and Healers, 113.
[16] Jutte, "German Barber-Surgeon and His Patients", 189.

The other primary expectation that patients had for their practitioners was trust. The secrecy surrounding the treatment of venereal disease emphasises the importance of trust in the patient-practitioner relationship. By the late seventeenth century, venereal disease was rampant. Regular practitioners commonly used mercury to treat venereal disease. This was not only uncomfortable for the patient, but the effects of the mercury treatment were so obvious (including copious saliva and a foetid smell) to anyone who knew the patient that the disease could not be concealed. Quacks capitalised on this area of specialisation, offering alternative and, most importantly, secret cures that did not incapacitate the patient and allegedly dispelled the visible signs of the disease. Moreover, many such practitioners had their lodgings in seedy, out-of-the-way areas, providing further confidentiality.[20] The 'trust' given to a practitioner had economic underpinnings.

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[17] Beier, Sufferers and Healers, 55, 58-60.
[18] Traister, "Matrix", 438.
[19] MacDonald, Mystical Bedlam, 36-37.
[20] Roy Porter, Health for Sale: Quackery in England 1660-1850 (Manchester and New York: Manchester University Press, 1989), 150-155.

If the practitioner entered a stable relationship with a wealthy patient, all of his services might be required at the patient's demand. Barbara Duden has studied the implications of 'trust' for a practitioner in her study of Johann Storch, a German physician. The aristocratic women whom he treated sent him frequent correspondence or messages, and in return, Storch sent prescriptions. He visited them at their request, regardless of time, sometimes more than once in a day. Since the aristocracy lived outside of Eisenach, such demands could be strenuous.[21] A similar expectation is occasionally revealed in the English sources. On 3 April 1639, Lady Brilliana Harley wrote that, although she did not think it serious, her husband had been ill of a cold for the past three days and had sent for Dr. Deodate. Two days later, the doctor had not yet arrived; by 6 April, Sir Robert was well again, but Brilliana impatiently reported that the doctor "is not yet come, nor the mesenger returned."[22] Patients, whether male or female, expected to receive the services to which they felt entitled through their payment.

Although feminist historians have often assumed that women were powerless in the patient-practitioner relationship, gender in itself had less influence on the dynamics of the patient-practitioner relationship of seventeenth-century England than has been thought. Early modern patients, both female and male, determined the dynamics of the relationships with their practitioners. This 'power' of the patient in the early modern period has been discussed in the greatest detail by Lucinda Beier and Roy and Dorothy Porter. They have identified two factors that made patients active in the patient-practitioner relationship. Whereas Beier has emphasised the importance of patients' own medical knowledge in their power, Porter and Porter depict economics as central to the patient-practitioner relationship.[23] Although Beier and Porter and Porter do not discuss the issues specifically in reference to female patients, these factors ensured that women would not be passive patients. Not only did women's medical knowledge often equal or surpass that of practitioners, but in the medical consumer culture of early modern England, the economic dependency of practitioners placed patients into a position of power. In contrast to the Harley's no-show Dr. Deodate, practitioners often eagerly provided their customer, male or female, with good 'customer service' in order to maintain their clientele.

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[21] Duden, Woman Beneath, 100.

[22] Lewis, Letters of ..., Lady Brilliana Harley to Edward Harley (3 April 1639), 38; same to same (5 April 1639), 40; same to same (6 April 1639), 41.

[23] Beier, Sufferers and Healers; Porter and Porter, Patients Progress.

In early modern England, no medical practitioner was so successful in curing that the unqualified submission of patients would be ensured. Patients knew that healers all had the common experience of failure, or only partial success. Furthermore, courses of treatment depended on the co-operation of the patient to undertake exercise, travel to health spas, or bed rest.[24] One patient of John Symcotts sought treatment to prevent miscarriages and for her lameness, which Symcotts diagnosed as a "decumbency of humours." Since the patient solicited his assistance through a letter, Symcotts had no way to ensure that she followed his course of treatment. Symcotts suggested that she take a series of vomits as soon as the symptoms arose. Then, over three or four days, she was to take purgatives. The next step was to take asses milk for twelve to fourteen days. Her "worst task" would be to regularly drink barley-licorice water. In the event that she became pregnant, at any sign of miscarriage, he recommended further purgatives and hoped that she would "be pleased" to take cordial electuaries. Moreover, Symcotts strongly suggested that the woman avoid other common treatments, such as astringents, bleedings and plasters.[25] This course of treatment required that the patient obtain the medications, at least one of which (barley-licorice water) had to be made by the patient. Similarly, the patient chose whether or not to follow the medical advice. As such, patients had confidence in their own knowledge to debate or demand their own treatments. In seeking treatment, patients often wanted the 'blessing' of the professionals for their own self-treatment process. John Cotton wrote to Symcotts three weeks after Mrs. Cotton had a baby, and thought "it now convenient for her to use some abstersive physic", requesting that Symcotts "consider what [he] think be most proper for her."[26] Patients also sought assistance because they were uncertain about their complaints, if their self-treatment was not working, or if they were so ill that they required help. In turn, doctors claimed that they were called in too late, only to give assistance once further damage had been done through self-treatment.[27] Francis Willughby discussed the need to select midwives wisely. Although this was not specifically self-treatment, he expected that a woman should know well enough to choose a good midwife, or she would encounter difficulties. He compared a woman who "commit[ted] her body to the practice of a young midwife, that hath read a little in a midwife's book . . . and, perchance, not by her skil, but by nature's force, hath laid a woman, or two, in an easy and naturall birth" to "an unadvised passenger" at sea.[28] If a woman erred in her choice of midwife, an unskilled midwife would "afflict . . . by their unadvised wayes, and ignorant proceedings."[29] In case after case, Willughby related how he was summoned to difficult deliveries to correct the errors of the unskilled midwives, and therefore, ultimately, the patient's 'error' of judgement.

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[24] Porter and Porter, Patient's Progress ,13.

[25] Poynter and Bishop, Symcotts, John Symcotts to "Madam" (29 June 1660), 17-18.

[26] Ibid., John Cotton to John Symcotts (n.d.), 12-13.

Not only did practitioners need patients to cooperate in the treatments, but patients also decided how they 'used' practitioners. The German practitioner Johann Storch's patients frequently knew what their ailment was and tried to obtain the necessary remedies from him. Women undertook their own bleeding, purging, and stimulation of menses before going to him. One maid had a half-pint of blood drawn to stimulate her menses, while another self-prescribed a bleeding at the hand for her tooth-ache.[30] Similarly, the majority of the female patients merely asked Storch for a prescription; although they did not specify what the remedy should contain, they knew what effects they wanted to cure the problem. Since a hands-on examination rarely occurred, Storch had to rely on what the patient told him, which was not necessarily the entire story. Visiting Storch also acted as a "ritualistic confirmation" of a patient's self-assessment and selection of remedy; the doctor's opinion was used to confirm the use and effectiveness of the desired remedy.[31] The English evidence suggests a similar tendency. On one occasion, although Binns suspected pregnancy, he treated a woman who wanted to be bled to stimulate her menses.[32] Likewise, Symcotts and Goodwife Uster of Denton together determined that her short-windedness, wheezing, and consumptive state indicated asthma. When the drugs that Symcotts prescribed had proven effective, the Goodwife did not bother to use the seton under her arm that Symcotts had also prescribed.[33] Patients determined their own health care through requesting specific medicines and the ways in which they enacted their own treatments.

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[27] Porter and Porter, Patient's Progress, 53.
[28] Willughby, Observations in Midwifery, 73.
[29] Ibid., 10.
[30] Duden, Woman Beneath, 74-75.
[31] Ibid., 93-94.

The process of seeking alternate opinions also indicates the patient's role in defining the patient-practitioner relationship. Lady Anne Conway (née Finch) suffered from debilitating migraine headaches throughout her life. She constantly tried new drugs, treatments and practitioners in the hopes of alleviating her pain. Her relationships with and opinions about practitioners and their treatments form the dominant theme of her correspondence with friends and family. Although her situation of chronic illness was atypical, her attempts to find relief provide a detailed record of patient-practitioner relationships. Between 1652 and 1670, Anne received visits from five named physicians (Drs. Harvey, Ridsley, Hernshaw and Willis and F. M. Van Helmont) and two touch healers (Mr. Coker and Valentine Greatrakes).[34] Through correspondence, she also sought Mr. Boyle's powder, a special red powder made by a Welsh family, and Dr. Johnson's blue powder recommended by a friend.[35] Anne was most disappointed with the services provided by William Harvey. By the time that Anne became Harvey's patient by August 1652, Harvey was getting old, concerned primarily with his own health.[36] He suffered from debilitating gout "almost continually, and that must needs indispose him to the minding of such things as relates not to his own particular.”[37] In early 1652/3, Anne expressed dissatisfaction that “he pretends very much to study and lay my case to heart”, intending to end her “tryalles of Dr Harvey . . . very shortly.”[38] At the same time, Anne also decided to “make tryall” of a new practitioner, Dr. Ridsley, recommended to her by her friend Henry More.[39] Unable to find respite from her headaches, Anne continued actively to seek new treatments and practitioners who might provide alternatives. In 1654, she considered trying Mr. Coker's form of faith healing; in 1666, she did utilise Valentine Greatrake's skill of healing by touch.[40] She was also willing to try more drastic treatments. In 1654, she planned a trip to France so that she might try the treatment of the trepan, done by French physicians.[41] The patient, moreover, always set the limits for treatments. John Finch commended his sister's “resolution not to try many experiments on [her] own body in Physick, considering the small encouragement [she had] by the [rest?].”[42] When seeking treatment, patients considered several factors, as can be seen by Anne Conway's quest for a cure. Anne Conway's medical history demonstrates how a patient determined what treatments she tried and which practitioners she sought; in doing so, the patient recognised that none of the practitioners were infallible and that the treatments they prescribed did not always work.

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[32] Beier, Sufferers and Healers, 93.

[33] Ibid., 103; Poynter and Bishop, John Symcotts, "De Asthmate 1637", 68.

[34] Conway Letters. On Dr. Harvey and Dr. Ridsley see John Finch to Anne Conway (11 August 1652), 66; Henry More to same (6 January 1652/3), 69; Anne Conway to Henry More (26 January 1652/3), 71; same to same (9 February 1652/3), 73; Henry More to Anne Conway (4 April 1653), 75; same to same (4 April 1653), 76. On Mr. Coker see Robert Gell to Anne Conway (26 May 1654), 98; Henry More to Anne Conway (7 June, 1654), 100-102; On Dr. Hernshaw see Anne Conway to her husband (4 September 1664), 225; On Dr. Willis see Lord Conway to Sir John Finch (June 165), 240; On Greatrakes see Lord Conway to Sir Edward Dering (20 June 1666), 274; On Van Helmont see Lord Conway to Sir George Rawdon (12 December 1670), 326.

[35] Ibid., On the Welsh red powder see Henry More to Anne Conway (5 September 1654), 105; On Dr. Johnson's blue powder see Lady Conway to her husband (19 January 1655/6), 129; On Mr. Boyles' Ens Veneris (4 September 1664), 225 and same to same (16 September 1664), 230.

[36] Ibid., Anne's brother John Finch refers to Harvey (1/10 August 1652): "I thinke no man is able to administer the operation [opening an artery] so well as Dr Harvey", 66.

The patient's freedom to determine her treatment is further illustrated in two cases of Elizabeth Pepys. In August 1660, Elizabeth suffered from “her old pain in the lip of her *chose*.”[43] Instead of Elizabeth directly approaching Dr. Williams, who had treated her for this once before, her husband Samuel went to pick up an ointment and plaster from the physician.[44] Like many patients, Elizabeth knew what treatments she wanted prescribed. When Elizabeth's problem recurred in October, the physician-patient relationship remained indirect; Dr. Williams sent pills and plasters to Elizabeth.[45] Another eruption of the problem occurred in May and June 1661. Although further treatment was necessary, the Pepyses initially continued to treat the problem themselves. Samuel "put in a tent (which Dr Williams sent [him] yesterday) into the hole to keep it open until all the matter be come out."[46] Almost a month later Elizabeth thought that her "soare belly is now grown dangerous." Although Pepys mentioned that Dr. Williams paid a visit to Elizabeth, he neither described the meeting nor referred to his wife's ailment until its next occurrence.[47] However, it is evident that Elizabeth decided that further intervention might be needed. When Pepys next discussed his wife's "hollow sore place below in her privities", Elizabeth had consulted Mr. Holliard, a surgeon.[48] After the initial visit, Elizabeth allowed a physical examination, "lying [down] to expect Mr Hollyard the surgeon."[49] Pepys described the examination, reporting a fistula three inches deep. The surgeon recommended that it be cut open all along. Elizabeth planned to go ahead with the treatment, but insisted that only the surgeon and her husband be present. Ashamed of her ailment, Elizabeth did not even want her maid to see the surgery done.[50] When the time came for the surgery, however, Elizabeth was "so fearful" of the pain that she decided not to have it done.[51] The surgeon then began an alternative treatment of fomentations, which would be a greater trouble for the patient, but less painful. Moreover, appealing to his patient's need for trust, Mr. Holliard ensured the secrecy of the treatment. The maids would only think that treatment was for piles since Elizabeth was "loath to give occasion of discourse concerning it."[52] In the case of her gynaecological problem, Elizabeth Pepys remained in control of her treatment. She determined if and when she saw practitioners, decided how much of an examination was necessary, and retained the final decision of which treatment to utilise.

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[37] Ibid., Anne Conway to Henry More (9 February 1952/3), 73.
[38] Ibid.
[39] Ibid.; Anne Conway to Henry More (26 January 1652/3), 71.
[40] Robert Gell to Anne Conway (26 May 1654), 98; Henry More to Anne Conway (7 June, 1654), 100-102; Lord Conway to Sir Edward Dering (20 June 1666), 274.
[41] Ibid., Henry More to Anne Conway (19 September 1654), 106. Due to a death in the family, her trip had to be cancelled.
[42] Ibid., John Finch to Anne Conway (9 April 1653), 77-78.
[43] See Diary of Samuel Pepys vol. 1, 2 August to 8 August 1660, 213-217; 2 August 1660, 213. Pepys used French terms to refer to his dalliances and to parts of the female anatomy. He used *chose* to refer to the vaginal/labial area.

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[44] Ibid., 5 August 1660, 215.
[45] See Ibid., 27 October to 31 October, 276-279; 28 October 1660, 276.
[46] Ibid., vol. 2, 9 May to 24 June 1661, 96-128; 12 May 1661, 98.
[47] Ibid., 24 June 1661, 125.
[48] Ibid., vol. 4, 12 November 1663, 379.
[49] Ibid., 15 November 1663, 382.
[50] Ibid., 16 November 1663, 384.
[51] Ibid., 17 November 1663, 385.
[52] Ibid., 17 and 18 November 1663, 385-386.

Seventeenth-century medical practitioners generally considered physical examination to be unnecessary. As such, the practitioners had not only an obligation, but a need, to listen to the patients' complaints in detail. In contrast to later periods, when physical examinations made the words of the patients relatively unnecessary, the relation of a case history by the early modern patient was crucial to a practitioner's diagnosis and treatment. Until the nineteenth century, the physical examination of a patient, as was finally performed on Elizabeth Pepys, was rare. As Roy Porter notes, the physician who routinely gave a 'hands-on' examination two hundred years ago would have been considered eccentric, if not offensive.[53] Since the role of physicians was to determine the inner workings of the body, which they could not see, physical examination made little sense. In contrast, surgeons who were responsible for treating external problems were more likely to give a 'hands-on' examination.[54] Even then, as with Elizabeth Pepys, the patient dictated the physical limits of the examination and, if needed, operation. In early modern medicine, physical examination was not believed to be a sufficient procedure to diagnose an internal condition. Indeed, the patient told the doctor the problem, when and how the complaint had started, what caused the problem, the accompanying pains and symptoms, and how often it occurred. A patient also discussed her eating and sleeping patterns, bowel movements, recent emotional distress, and what remedies had been tried.[55] There was a brief physical component to the examination, which entailed checking the eyes and the pulse, looking at skin lesions or discoloration, listening to coughs, and sniffing the odour of pus and emissions; this, however, was secondary to the patient's recitation of the ailment.[56] Indeed, the popularity of obtaining medical advice by post emphasises the marginal importance of 'hands-on' treatment.[57] In an analysis of Johann Storch's medical practice, Duden found that, in many cases, Storch never saw the patient, although he might treat her over years. Instead, most 'meetings' went through intermediate channels: letters, oral reports, messages and requests. Noblewomen either wrote a letter or sent a servant; a mother asked advice for a daughter. Duden suggests that this deliberate distance was the most frequent type of relation between Storch and his female patients, based in social circumstances and language. Like the English practitioners, Storch thus diagnosed and prescribed based on the words of the patient and, perhaps, their bodily emissions.[58] Patients, moreover, expected that they would be allowed to speak their opinion and have the right to veto any treatment.[59] The failure of a practitioner to listen sufficiently to his patient was a breech of the relationship. Anne Conway's chief complaint about Dr. Harvey was that he was only "pretending" to listen to her case.[60] In contrast, although Valentine Greatrakes failed to cure Anne, both Anne and her husband thought highly of his "worth, and integrity."[61] Since diagnosis and treatment were a collaborative effort between the patient and practitioner, a respect for the patient and the patient's observations was crucial to a successful practice.

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[53] Roy Porter, "The Rise of Physical Examination", 179-197 in Medicine and the Five Senses ed. W.F. Bynum and Roy Porter (Cambridge: Cambridge University Press, 1993), 179.

[54] Ibid., 185.

[55] Ibid., 181-182.

[56] Ibid., 183.

[57] Porter and Porter, Patient's Progress, 76-77.

On the rare occasions that a practitioner physically examined a female patient, the practitioner had to be circumspect. The German physician, Johann Storch, for example, seldom touched the bodies of female patients, and when he did so, he always made a careful note of it. Duden notes that this distance was not related to social class. Even in the cases of the poorest woman and a 'strumpet', whom he visited in prison, the women did not have to let him see their bodies unless they expected to benefit from it.[62] Porter suggests that while women were not worried about discussing intimate physical problems with practitioners, a physical examination caused anxiety for both the patient and her family.[63] In part, this was due to the gradually changing perceptions of modesty. Michel Foucault has placed the first "rupture" of the history of sexuality in the seventeenth century, characterised by new sexual prohibitions, promotion of adult marital sexuality, ideas of "decency", and "the obligatory concealment of the body."[64] Robert Muchembled has also traced a surge of sexual repression between 1550-1700 in France. New rules of proper conduct and the bedroom as a separate space emerged, the habit of sleeping nude disappeared, and underwear came into use. Moreover, nudity became taboo and modesty increased. Everything related to sexuality and excretion became part of the realm of individual intimacy.[65]

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[58] Duden, Woman Beneath, 81-84.
[59] Porter and Porter, Patient's Progress, 87.
[60] Conway Letters, Anne Conway to Henry More (9 February 1652/3), 73.
[61] Ibid., Lord Conway to Sir Edward Dering (20 June 1666), 274.
[62] Duden, Woman Beneath, 84.
[63] Porter, "The Rise of Physical Examination", 191-194.

Porter, in contrast, notes only a gradual development of modesty in England; during the seventeenth century, the body continued to exist publicly in many ways. For example, Pepys entered a public room at the Earl of Sandwich's to find the Duchess "doing something upon the pott."[66] Nonetheless, society viewed physical contact between patient and practitioner with scepticism. Even in the seventeenth century, the image of the surgeon-accoucher was paralleled with that of a sexual predator. Pepys wrote that Mr. Blurton, a friend of a friend's, visited a local tavern and convinced its mistress that Blurton was a doctor. The woman then "did privately discover her disease to him" and invited Blurton to return to treat her. When he returned, he "hath the sight of her thing below, and did handle it--and he swears the next time that he will do more."[67] Accordingly, a physical examination presented an element of 'danger' to the female patient. An anxiety that physical contact between patients and practitioners might lead to a breakdown of moral barriers existed.[68] When Elizabeth Pepys received treatment for her vaginal fistula, both Samuel and Elizabeth were concerned. To them, a physical examination was shameful. As already discussed, Elizabeth was "loath to give occasion of discourse concerning it." Porter, moreover, suggests that Samuel was perturbed, perhaps jealous, of exposing his wife's ailment to the public knowledge of a nurse and her maids, in addition to the surgeon.[69] Samuel was quite insistent that his wife need not be ashamed as the problem was "nothing but what is honest"; such a problem, however, might indicate to others a venereal disease, with its moral implications for both his wife and himself.[70] While medical examination and intervention were clearly needed, neither Elizabeth nor Samuel wanted anyone else to know of the problem; the surgeon's gaze was difficult enough. Furthermore, this drastic form of assistance was not sought until Elizabeth's problem appeared to be getting worse. With the concerns of modesty, embarrassment, and possibly humiliation involved in physical examinations, bedside conduct required rules of propriety. However, as Porter discusses, the norms of the propriety of the body constantly fluctuated. The Restoration was especially a confused period as people rejected many of the Protectorate restrictions on the body and sexuality.[71] In seventeenth-century England, social meanings imbued any touch between patient and practitioner. Just as Storch took care not to invade any of his female patient's boundaries, on the few occasions that English practitioners went beyond the normal perimeters of the patient-practitioner relationship, a significant reason would have been needed and the examination solicited by the patient herself. Thus, within the patient-practitioner relationship, the patient determined the physical 'limits' of the examination.

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[64] Michel Foucault, The History of Sexuality vol. 1 trans. Robert Hurley (New York: Vintage Books, 1990), 119.

[65] Robert Muchembled, Popular Culture, 189.

[66] As quoted in Porter, "The Rise of Physical Examination", 185-187; Latham and Matthews, Diary of Samuel Pepys, vol. 8, 422.

[67] As quoted in Porter, "The Rise of Physical Examination", 187; Latham and Matthews, Diary of Samuel Pepys, vol. 2, 43.

[68] Porter, "Rise of Physical Examination", 187. This idea became more prevalent in the eighteenth century.

[69] Ibid., 192-193.

Since patients did not usually submit to a physical exam, the patient selected what and how much she told the practitioner. In certain cases, this permitted the female patient to obtain treatments without the practitioner ever being certain for what problems the treatments would be used. For example, Joseph Binns provided treatment to induce a young woman's menses; in a similar case, Johann Storch believed that a woman receiving treatment for stopped menses was pregnant, but was not certain until he paid a house-call, surprising her while she was scantily clad, which revealed a pregnancy.[72] As Duden points out, patients often had specific remedies in mind, even though they did not always tell the practitioner precisely what the problem was.[73] In cases of venereal disease or women's diseases that a patient did not wish to divulge in full, the ability to conceal the truth would have been an asset.[74] In Binns' practice, Beier has found that many people complained of problems more innocent than venereal disease, such as a chronic headache or sore throat, which were also symptoms of venereal disease. "My cousin Spooner's sister" consulted Binns for "extreme pain in her head" which hurt somewhat worse at night. When she developed nodes on her forehead and shoulder pains, Binns prescribed a mercury flux, the treatment for syphilis. Beier suggests that such attempts at concealment could indicate that more patients of his might have been syphilitic.[75] This theory of concealment, however, is problematic, as it assumes that the women realised that they had contracted a venereal disease. Even today, many STD's can pass undetected in women until severe internal complications, such as sterility, are caused. In many cases, a woman probably would not have realised what her problem was; she would have had to be aware that her sexual partner had a disease.[76] Nonetheless, women could manipulate their medical treatment in other ways for a variety of embarrassing or awkward problems. As in the cases of Binns and Storch, a woman might surreptitiously seek an abortion by claiming that her menses needed to be induced. The power of the patient to determine what the practitioner learned can be seen in an example from the eighteenth century. Anna Seward commented on Erasmus Darwin's "extreme . . . scepticism to human truth. From that cause he often disregarded the accounts his patients gave of themselves", instead collecting his information "by indirect inquiry and by cross-examining them."[77] Without examining a patient's body, the practitioner had to rely on the words of the patient; as such, women could obtain treatment for problems that they did not explicitly reveal to the practitioner.

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[70] Latham and Matthews, Diary of Samuel Pepys, vol. 4, (17 November 1663), 385.
[71] Porter, "Rise of Physical Examination", 187-188.
[72] Beier, Sufferers and Healers, 93; Duden, Woman Beneath, 85.
[73] Duden, Woman Beneath, 93.

The patient-practitioner relationship was not the only way in which a sick person held 'power'. First of all, the woman decided at what point she was ill enough to warrant disrupting the household. Secondly, the sick role allowed a respite from daily tasks and the opportunity for special interest to be paid to a woman by friends and family.

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[74] Porter, "Rise of Physical Examination", gives an example from 1821 in which Anne Lister asked for a venereal diseases treatment for a friend, 191-192.

[75] As quoted, Beier, Sufferers and Healers, 93.

[76] Abram Benenson (ed.) Control of Communicable Diseases in Man 15th ed. (Washington: American Public Health Association, 1990). See entries on 'Syphilis', 420-426 and 'Gonococal Infections', 185-190.

[77] As quoted, Porter, "Rise of Physical Examination", 183.

Adoption of a sick role could in some cases be an attempt of a woman to gain direction to her life. The power of adopting a sick role, however, was more limited than that of the patient-practitioner relationship. At certain points, a woman might lose control over her health care as her family took over from her or tried to control her actions. The process of lying-in was a highly ritualised 'sick role' which focused on women. An examination of the lying-in rituals illustrates the adoption of a sick role, the extent of a woman's control over her own body, the point at which she might lose that control, and the social importance of a sick role.

To a large extent, the adoption of a sick role depended on a woman's family responsibilities and social status. A disorder that confined a sufferer to bed for more than a couple of days disrupted the entire household. Even in cases where one was not in serious danger, the household accommodated the sick person. Beier argues that taking on the sick role was a matter of choice. In many cases, a sick person might carry on as usual, perhaps grumbling about discomfort, but continuing to be active, because of the disruptions that would otherwise occur.[78] As such, a wealthy woman could more readily become 'ill' than a less wealthy woman; a woman with many servants to take over her duties had less reason to continue daily life in discomfort than a woman who had many responsibilities devolving on her. Lady Brilliana Harley spent much of her time complaining of being ill, and in fact, remaining in her chamber, if not her bed. Between January 1638/9 and August 1641, she reported being unable to rise from her bed for at least three days (and often longer) sixteen times. Two other times, she appears to have remained essentially chamber-bound for a month.[79] However, she lived in a large household and could rely on the assistance of domestic servants. Elizabeth Pepys also became bed-ridden frequently; for example, she often took to her bed when she had her menstrual period.[80] However, even a short time removed from household duties in her case could disrupt the household. While her husband was generally sympathetic to her during her menses and times that she was obviously ill, he expressed displeasure at her shirking of household duties. On 27 March 1660/1, Elizabeth "not being well" of an unspecified problem kept to her chamber; on 31 March, she was "unwilling to dress herself" and the house was "all dirty."[81] Likewise, he was annoyed when she returned from having a foretooth drawn out, in part because he was "now in the greatest of all [his] dirt."[82] Jane Josselin, with her large family and only one maid, in contrast, seldom took to her bed while she was ill. Between 1642 and 1683 , Ralph Josselin reported only 48 instances of Jane being unwell, ranging from childbearing related problems, to tooth-ache, to being sickly with looking after an ill baby.[83] Depending on social status and responsibilities, the sufferer decided at what point her illness was severe enough for her to become a patient.

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[78] Beier, Sufferers and Healers, 243-244.

[79] Letters of Brilliana Harley. To Edward Harley (22 November 1639), 73-74, she reported that she had not been abroad in thirty days. On 1 April 1641 she wrote that she had been ill since Wednesday and she did not note getting out of bed until 30 April 1641, 123, 126-127.

[80] Latham and Matthews, Diary of Samuel Pepys. For example, the first reference is on 5 January 1661/2 (vol. 3), 3. For that year, also 13 May 1662, 82; 16 June 1662, 111; 24 December 1662, 290. Her sick role

Becoming a patient provided the sufferer with a measure of power. Not only was the sick person removed from the daily activities of the household, but she was treated differently. Friends and neighbours visited the invalid, while the family cared for the patient, and remedies were sought. In turn, the patient was expected to act differently. She remained in bed, was waited upon, and took medicines. The household, moreover, reorganised itself around the sufferer; the family members were the care-givers in addition to taking on the woman's usual duties.[84] To some extent, Elizabeth Pepys exerted some power over her husband, Samuel, through her adoption of the sick role. Not only did she leave the house dirty, perhaps in a passive resistance, but she also became the focus of his attention again. For example, during his wife's menstrual periods, Samuel often joined her for dinner in their chamber.[85] Sick-room visits were an integral part of a sufferer's experience. The visitors supplied their services and comfort to the

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because of menstruation occurred more often, and for longer times, the following year 1662/3 (vol. 4): 21 January, 20; 17-19 February, 48; 20 March, 80; 31 May, 164; 1 June, 168; 9-11 December, 409.

[81] Ibid., vol. 1, 61, 63.

[82] Ibid., vol. 1, (8 May 1661), 96.

[83] Beier, Sufferers and Healers, 187, 205-206.

[84] Ibid., 206-207, 243.

[85] For example, Latham and Matthews, Diary of Samuel Pepys (vol. 4), 19 February 1662, 48 or 20 March 1662 when he dined by his wife's bedside because she was "in great pain abed of her months."

invalid.[86] Lady Margaret Hoby several times mentioned both visiting the sick and being visited while she was sick. On 7 June 1605, for example, she went with Mr. Ward, Mr. Rhode, and Mrs. Netelton to visit her cousin's sick wife.[87] Margaret had visitors several times while she was sick. From 23-26 December 1600, she kept to her chamber because of a cold and was visited each day by Mrs. Thortiborrowe.[88] In addition to disrupting one's own household, one might affect other family members. Family members from outside of the household also acted as caregivers. On a couple occasions, for instance, Margaret went to care for her mother and her mother came to care for her.[89] In the social role of patient, a woman was temporarily at the centre of attention.

In some cases, the sick role provided a woman with a purpose. Historians of women for later periods, especially the nineteenth century, have discussed the female invalid of that period as exercising control over the people around her, demanding that she be the perpetual focus of attention. This was one method of providing meaning to her existence.[90] One can infer such a pattern for Elizabeth Pepys' life. For example, she often became sick, or suffered painful menstrual periods, after she had quarrelled with her husband or wanted attention. One example of this was Samuel's brief statement on 23 November 1662 that "My wife not being well today, did not rise." The previous day she and her maid Sarah had quarrelled. Moreover, Elizabeth was lonely and had repeatedly asked her husband for a companion, to no avail.[91] More explicit was Brilliana Harley's situation. After a year and a half of almost constant illness, Brilliana was getting frustrated; "as soune as I am pretty well I am ill againe", she bemoaned. Although Dr. Deodate expressed pity for her, he told her that "he knowes many so."[92] In May of the following year, she revealed a sense of uselessness to her family: "it is my greefe that my condistion in health is such, that I can not be of more aduantage to you all than I am."[93]

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[86] Ibid., 248.

[87] Diary of Lady Margaret Hoby, (7 June 1605), 234.

[88] Ibid., (23 December 1600), 130.

[89] Ibid., (6 October 1600), 112; (18 July 1601),166.

[90] Cf. Ehrenreich and English, For Her Own Good: 150 Years of Experts' Advice to Women, 97-99.

[91] Latham and Matthews, Diary of Samuel Pepys vol. 3 (22 and 23 November 1662), 263-264. In early December, she finally had a companion, Gosnell; however, Gosnell left within a week for another duty.

[92] Letters of Brilliana Harley, To Edward Harley (3 July 1640), 98.

[93] Ibid., To Same (21 May 1641), 132.

The year 1641/2 brought better health for Brilliana, as she reported only seven incidences of illness; this coincided with the political difficulties arising in Essex. In the Harley's immediate neighbourhood, they were one of the few Parliamentarian families. In such a situation, Brilliana likely had no time to be sick. She needed to supervise the household while her husband was in London almost constantly. In July 1642, she wrote that she had "great caus to blees God for His great mercy in giuing me, now at this time, a fare more full measure of health than I haue ever had, ever sence I was ill."[94] The local problems escalated until on 15 July 1643 their castle came under siege. Brilliana did not mention any ill health until October 1643 when she sickened just before she died. In the last letter she wrote to her son, she believed that her "very greate coold" would go away, realising that "it is an ill time to be sike in."[95] Whereas Elizabeth Pepys' unspecified sicknesses appeared at times when she seemed especially to be without a 'purpose' or lonely, Brilliana Harley's illnesses disappeared when she became more 'useful' to her family. In this way, sickness could provide women with an outlet for their frustrations and a subconscious opportunity to have a 'purpose'.

The 'power of the patient', however, had its limitations. Patients themselves could end up in the middle of a 'power' struggle between those close to them. In 1640, Brilliana Harley wrote that her son Tom had ague. However, when the nurse 'made so much fier' that it almost burned the bed-clothes, Tom was "put . . . into a violent heate." Brilliana caught the problem in time and "now . . . haue him lye in the chamber by me."[96] Although the recommendation of treatments and practitioners was often for philanthropic motives, those providing the recommendations were sometimes covertly disapproving, because sickness betrayed bad family management. Control might also be exercised through medical knowledge.[97] As mentioned, Samuel Pepys often became frustrated with his wife's avoidance of household duties through illness. Thus, Elizabeth's sicknesses held moral ramifications as she was not fulfilling her role as wife. Likewise, the correspondence 'network' around Lady Anne Conway's headaches indicates power games.[98] Selection of a practitioner was one form of control. When Anne began to see Dr. Harvey, her brother John Finch thought that he would be good; yet, her father-in-law recommended that she find another one, despite her "great good opinion" of him.[99] When Henry More learned that Anne was looking for another physician, he insistently put forward the names of the young and old Dr. Ridsleys.[100] Henry More also claimed that her headaches would improve if she did not think and read so much. He further used the advice of Dr. Ridsley to bolster his argument, "which I have been told to charge upon your ladiship heretofore."[101] Nonetheless, Anne Conway remained the primary determinant of her health care, accepting or ignoring advice as she chose. In other situations, those close to invalids might lose their sympathy. A mutual friend of Lady Jane Cornwallis and Lady Bedford claimed that "my Lady of Bedford wynnes still upon her health."[102] Sir Charles Lyttelton was frustrated by his wife's ill health in Jamaica. Her illness meant that she could not live near the sea-shore, which was where he was obliged to be, resulting in the keeping of two households. A touch of sarcasm appeared as he claimed that his "poore wife has bine, as it were a miracle, raised to life twice with Sir W. Rawleigh's cordiall, when given over by her phizitians and all her friends."[103] Although limits to a patient's power might arise when her family became frustrated with her or sought to determine her treatment, the extent of a patient's power becomes especially apparent in a family's frustration in dealing with a long-term invalid's changed status.

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[94] Ibid., To Same (15 July 1642), 177.

[95] Ibid., To Same (9 October 1643), 209.

[96] As quoted in Porter and Porter, Patient's Progress, 41; Letters of Brilliana Harley, 119.

[97] Porter and Porter, Patient's Progress, 43.

One sick role held exclusively by women was that of pregnancy and childbirth. Not only were pregnancy and childbirth the times at which most women came into contact with medical practitioners, but these 'sick roles' were controlled exclusively by women. The tradition of 'lying-in' was not only a rite of passage,[104] but can also be seen as a type of patienthood. In early modern culture, pregnancy was perceived to be an illness. As previously discussed, women were allowed, if not expected, to be 'sick' during pregnancy.[105] After childbirth, during the three to four weeks of lying-in, women also followed a socially prescribed sick role. Women seldom held greater social status and power than when they were pregnant or lying-in. Seemingly contradictorily, an individual woman lost control over her body during the birthing process; yet, at the same time, the woman ceded her power to other women acting on her behalf. The 'sick' role of lying-in and the occasion of childbirth exemplify the power, and the limits of power, held by women over their own bodies.

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[98] Ibid., 43.

[99] Conway Letters, John Finch to Anne Conway (1/10 August 1652), 66; Lord Conway to his daughter-in-law (1 July 1651), 29.

[100] Ibid., Henry More to Anne Conway (6 January 1652/3), 69.

[101] Ibid., Henry More to Anne Conway (4 April 1653), 75-76.

[102] Jane, Lady Cornwallis, T. Meautys to Jane Lady Cornwallis (Easter night 1627), 169.

[103] Hatton Correspondence, Sir Charles Lyttelton to K. Lyttleton (13 January 1662/3), 29-30.

[104] Wilson, "Ceremony of Childbirth"; idem., "Participant or Patient".

A woman's status became higher during pregnancy than at any other time in her life. Primarily, this was because the life she was carrying took precedence over her own. The best ante-natal care involved watching one's diet, getting proper rest and exercise, and avoiding strong passions of the mind.[106] Some allowance was made for pregnant women to break fasts or satisfy their cravings. In 1634, Anne D'Ewes "took some small sustenance" on a fast day, while Lady Barbara Compton asked William Bagot to send her daughter venison, for "many times, great bellied women think of such novelties."[107] Sexual intercourse, at least in the first trimester, was to be avoided, lest the child be shaken loose and the menses stimulated.[108] If one were to have intercourse, being that "the Nature of Man is so vicious that he must have to do with his Wife", it should be moderate; after all, prostitutes rarely bore children because "Grass seldom grows in a [well-trodden] Path."[109] Any control that a woman exercised over her body, or special treatment that she received during pregnancy, was for the sake of the child she carried.

Although her status may have been highest during pregnancy, a woman had the greatest control over her body during the lying-in month after childbirth. At this time, a woman's body not only became her own because she had been delivered, but because her husband's access to her sexuality and to her availability for physical labour became limited. Adrian Wilson has discussed the 'political' meaning of lying-in. According to common law, the husband owned his wife's property, her ability to labour and produce, and her sexuality, but during the lying-in month, the wife was physically withdrawn from her husband.[110] The woman's lying-in chamber was a separate physical space. Even if a woman did not have the space for a separate room, she might have stayed at her mother's or a friend's house, or she might have merely curtained off her bed.[111] She also had a separate social group, the company of women. This group of women may have played a role in ensuring that the husband respected his wife's removal from daily life.[112] After childbirth, a friend or near relative commonly remained with the new mother. Among the wealthier classes, a nurse would generally be hired to perform the mother's normal household tasks. Jane Josselin, for example, hired a nurse after at least three of her deliveries and on one occasion, Mrs. Harlakanden stayed with her.[113] Medical practitioners, as well as the women, further recommended a period of sexual abstinence following birth. Simon Forman outlined the evils that might occur if "a woman suffer a man to lie with her when she is yet grene after she is deliuered", chiefly that the man's seed would enter the matrix and rot there, later causing back and genital pain.[114] After childbirth, society allowed a woman control over her body.

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[105] Chapter 1, 35-37.
[106] Eccles, Obstetrics and Gynaecology, 61.
[107] As quoted in Pollock, "Experience of Pregnancy", 50-51.
[108] Eccles, Obstetrics and Gynaecology, 62.
[109] Ibid., As quoted from Culpeper and Aristotle, 63.

The new mother's return to her daily life and contact with the male world was gradual. For the first week, she remained in bed, receiving only female visitors. After the 'upsitting', her bed clothes were changed and she moved about the chamber. During the third stage, she went about the house and was allowed to visit with male relatives.[115] Wilson points out that women continued this ritual because it was in their interests; the ceremony of childbirth allowed the new mother a period of rest and recovery and kept the management of childbirth under female control.[116] The lying-in month ended with the ecclesiastical rite of 'churching'. Although churching initially appears to be a male imposition by implying that women were impure after childbirth, women themselves maintained the custom. Even in Puritan London, ninety percent of new mothers followed the custom.[117] Churching was criticised by both men and women, but these criticisms were highly gendered; women focused on the forms of the tradition, while the men argued against the act. In 1630, Mrs. Pinson of Wolverhampton refused to go veiled, but wanted the churching. In contrast, Richard Morley of Grantham, in 1589, claimed that "the churching of women is a beggarly ceremony . . . [by which] those which do use it do in some respect forsake Christ."[118] Churching, like the lying-in ritual, had a meaning for women; the churching legitimised the entire ceremony of childbirth.[119] Whereas women, like Elizabeth Pepys, might utilise their repeated adoption of the sick role to deny their husbands their physical labour and their sexuality, the lying-in month offered the only socially condoned way to physically separate oneself from daily life. The lying-in month, an extension of invalidism as well as a ritual, allowed women the greatest opportunity to control their bodies in a socially acceptable manner--even if at the end of the month, the woman's sexuality and labour once again reverted to her husband.

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[110] Wilson, The Making of Man-Midwifery, 29; "Ceremony of Childbirth", 85-86. He uses the arguments of Natalie Zemon-Davis for the "woman on top" inversions of popular culture and sees the lying-in as a reversal of the husband's normal dominance.

[111] Idem., "Participant or Patient", 139.

[112] Ibid., 140; Idem., Making of Man-Midwifery, 29..

[113] Idem., "Ceremony of Childbirth", 76.

[114] Traister, "Matrix", 441.

[115] Wilson, "Participant or Patient", 138.

[116] Idem., Making of Man-Midwifery, 29-30.

To some extent, a woman lost her individual power over her own body during the process of childbirth; however, when the woman gave up her control, she placed herself in the care of women whom she had chosen. An expecting mother selected those women who would attend her at birthing. The choice of a midwife was especially important. If the woman did not know the midwife personally, the recommendation of family members was necessary. Joan Thynne requested that her sister "provide [her] of a good midwife" for around Easter; there were no local ones to be had since Goody Barber had died.[120] Likewise, the Oxindens sent a midwife to Francis Tilghman's wife. Tilghman thought that the midwife would also serve his "sister Saunders' turne."[121] The expecting mother also determined whom she invited to the birth as her gossips, or witnesses. Just as the receipt of such an invitation was a compliment and to refuse it was a slight, the expecting mother might later feel guilty for not inviting a particular acquaintance. Primarily, the gossips consisted of a woman's closest friends and related women.[122] In 1629, Lady Joan Barrington's attended one of her daughter's lying-in. When possible, a woman's mother or mother-in-law attended the birth.[123] It is significant that in preparing for birth and lying-in, the woman chose her practitioner and her gossips. When a woman relinquished her medical control during the birth process, she ceded that control to people in whom she had put her confidence.

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[117] Idem., "Ceremony of Childbirth", 88.

[118] As quoted Ibid., 90-91.

[119] Ibid., 92.

[120] Elizabethan Women, Joan Thynne to John Thynne (10 March 1589/90), 6.

[121] Oxinden Letters, Francis Tilghman to Richard Oxinden (20 January 1625), 24.

The midwife was in charge of the birth, telling the mother when to bear down or rest, what position to assume, and what to eat or drink.[124] In the majority of births, there were no complications. However, the recorded cases in which complications did occur depict the conflict between the midwife, the mother, and the gossips, as they struggled to control the situation. When complications occurred that the midwife could not handle, she summoned another midwife. If no midwife could deliver the child, both the child and mother were endangered. Desperate situations called for a desperate remedy--sending for a male practitioner, a surgeon, who could extract the dead child with instruments. The women present would avoid calling in a surgeon until the last minute; in requesting assistance, they were giving up hope for the child and subjecting the woman to a painful and frightening operation.[125] Percival Willughby's Observations in Midwifery provides the most detailed record of the conflicts that transpired when the midwife, mother, and gossips disagreed. In 1640, he was standing by in the delivery of an aristocratic woman. She suffered great pain after the child's head had emerged, and asked for Willughby's help, but the midwife "said that my Lady must stay God's time and pleasure."[126] On another occasion, Willughby was called to the delivery of a shepherd's wife, to remove the dead child. The mother complained to him how one midwife "had afflicted her through much pulling and stretching of her body."[127] After five deliveries, Mrs Molyneaux called midwives "ignorant creatures" who in difficult births only "haul[ed] and pull[ed]" the woman and child.[128] Conflict might also occur between a mother and the gossips. One woman, after spending a day in labour, called her gossips "hard-hearted Jews" for not sending for the surgeon. They relented shortly after.[129] Wilson concludes that women during the birthing process were "perhaps less of a participant, and more of a patient."[130] Nonetheless, although the woman did not have complete control over her body during childbirth, she had chosen the people to whom she gave control of her body; furthermore, because the woman ceded her control to other women, she ensured that her body remained in the care of women.

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[122] Wilson, "Participant or Patient", 134.

[123] Barrington Letters, Lady Elizabeth Masham to Lady Joan Barrington (early October 1629), 94; James Harrison to Lady Joan Barrington (October 1629), 94.

[124] Wilson, "Participant or Patient", 135

[125] Ibid., 137.

[126] Ibid., 143; Willughby, Observations, 226.

The ability of the practitioner in charge to over-ride the authority of the patient only appears to have occurred in the case of childbirth, and then only in dire circumstances. As previously discussed, for most medical problems, women determined the treatments that they received. However, the question of whether medical treatments themselves reflected the misogyny of medical theories remains to be answered. During the seventeenth century, the medical practitioners' treatment of women's problems did not disadvantage women or, in practice, reinforce the misogyny of formal medicine. Francis Willughby, for example, had used his knowledge of midwifery in the hope of easing women's pains.[131] In application, medical theory and medical practice often diverged. Through a brief examination of the medical treatments for a female and a male specific problem (hysteria and venereal disease), men appear to have been at a slight disadvantage; women's problems were, on the whole, treated by physic, whereas men's problems were more subject to treatment by surgery. Once women placed themselves into the care of a medical practitioner, they did not submit themselves to a passive role; not only did women retain autonomy over their own care, but the common treatments for women's problems did not disadvantage women.

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[127] Wilson, "Participant or Patient", 143; Willughby, Observations, 47.
[128] Wilson, "Participant or Patient", 143; Willughby, Observations, 146.
[129] Wilson, "Participant or Patient", 143; Willughby, Observations, 38.
[130] Wilson, "Participant or Patient", 144.
[131] Willughby, Observations, 20. He wanted to "perswade all midwives" "not to do any thing hastily, or by force, to enlarge the passages", which would be "hurtfull both to the mother and child."

As we discussed in Chapter One, many of women's diseases were attributed to the unhealthy and imperfect nature of women's bodies. Early modern formal medical theories considered women to be subject to the whims of their wombs, especially assuming a close relationship between women's mental/emotional states and their wombs.[132] Hysteria, for example, was one of the most 'morally charged' women's diseases. Dr. Thomas Sydenham claimed that hysteria was a chronic disease from which the majority of women suffered at some point. According to Sydenham, hysteria and hypochondria were similar diseases and so men might also suffer from this disease; nonetheless, women were more prone to this type of disorder.[133] A disordered mind characterised hysterical patients:

> Upon the least occasion also they indulge terror, anger, jealousy, distrust, and other hateful passions; and abhor joy and hope and cheerfulness . . . [and if they should happen to arise] disturb the mind as much as the depressing passions do; so that they observe no meaning in anything, and are constant only to inconstancy. They love the same persons extravagantly at one time, and soon after hate them without a cause; this instant they propose one thing, and the next change their mind, and enter upon something contrary to it but without ever finishing it; so unsettled is their mind that they are never at rest.[134]

Women on the whole were considered to be irrational; Sydenham's theory of hysterical irrationality, thus reinforced the idea that women were irrational by nature, and therefore prone to the irrationality of hysteria. Despite such cultural assumptions, the medical treatments for women's diseases were not 'misogynistic', and instead followed the common methods of treatment used for other diseases. For Mr. Hill's sister of Titchmarsh who suffered from fits of the mother, Dr. Symcotts prescribed a vomit, two types of pills and a "potent opening" decoction; although these treatments failed, he recommended with more success that she have blood let from her arm and that she take laudanum for five or six nights. Symcotts used similar treatments for other patients.

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[132] See pages 8-11.
[133] Thomas Sydenham, "Episotalry Dissertation to Dr. William Cole on Recent Observations Upon the Cure of Confluent Small-Pox and on the Hysterical Affections", 130-141 in Selected Works of Thomas Sydenham, M.D. ed. John D. Comrie (London: John Bale, Sons & Danielsson, Ltd., 1922), 130-131.
[134] Ibid., 134-135.

Mistress Leigh at Sandy was relieved of the fits after bleeding, while Mistress Judith Becher of London was given laudanum, mild mercury, and pills.[135] In his diaries, John Locke likewise recorded several remedies for hysteria. Dr. Barbirac considered hysteria to be a species of epilepsy; he recommended that a hysteric be bled, have a vomit of Mercury of Life, and take repeated baths, other types of medicines, and a cooling diet.[136] In contrast, Dr. Donalson used only *sal volatile*.[137] An "AE" suggested that a patient should be purged over two or three days then take asafoetida for four or five days. If the asafoetida did not agree, then a pill of wormwood was to be taken with wormwood wine or beer for twenty days.[138] Within the understanding of seventeenth-century medicine, none of these treatments was particularly brutal or punishing; purging, vomiting, and bleeding were standard procedures for treating many diseases.[139]

Hilda Smith has pointed out that medical practitioners' belief that they needed to administer to women's internal sexual system in all diseases was in itself misogynistic and allowed for useless and brutal treatments to be employed.[140] However, first of all, not every physician agreed that the womb was the source of women's problems. Thomas Willis perceived such a problem in the seventeenth-century when he wrote that, most often, the brain and nervous system were affected rather than the womb.[141] Indeed, Smith's assertion is only partially correct. While physicians certainly skewed the perceptions of women's health by tending to focus on women's sexual organs, there were no other forms of treatment available to treat "mental disorders" within the early modern concept of medicine. Even men suffering from hysteria/spleen/hypochondria received similar treatment. Dr. Godefroy treated a priest who suffered from hysterical fits with pills of tachamahaca.[142] Moreover, the treatments for hysteria were not necessarily harsh in effect. For example, asafoetida was also used for flatulence and constipation.[143] Although the theoretical basis of hysteria assumed the inferiority of women, the treatments for hysteria, no more brutal than any other seventeenth-century treatment, did not reinforce the gendered assumptions of the theories.

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[135] Casebook of John Symcotts, "De affectu historico", 6 September 1637, 68.
[136] Dewhurst, John Locke, 18 June 1675, 69.
[137] Ibid., 20 August 1677, 88.
[138] Ibid., 20 June 1679, 166.
[139] These treatments compare favourably to those of the nineteenth-century when surgical intervention, such as ovariotomies, was becoming popular in treating hysteria and other women's diseases.
[140] Smith, "Gynaecology and Ideology", 102.
[141] Martensen, "Transformation of Eve", 107.
[142] Dewhurst, John Locke, 15 July 1678, 131.

In comparison to the treatments offered for hysteria, men's 'moral' disease--venereal--received a relatively harsher treatment. Thomas Sydenham, who considered gonorrhea and syphilis to be manifestations of one disease, described the moral implications of venereal disease:

> I have met with several, who either with a good intent, in order to deter the incontinent from their vicious practices, by the apprehension of the succeeding punishment, or to acquire the character of chaste persons themselves, have not scrupled to assert that the cure of the *venereal disease* ought to be kept secret.[144]

Physical deformity was frequently thought to represent the quality of one's mind or morals.[145] Likewise, to early modern people, social and moral disorder went together--in this case, causing a visible disease.[146] Sydenham traced the disease itself to 1493 when the 'Spaniards' brought it back from the West Indies; he believed that they had been infected by the 'Negroes' purchased in Africa ("a barbarous custom").[147] Not only did Sydenham point out that it was brought by Catholics, but that it was linked to both the mysteries of Africa and to the abominable practice of slavery.[148] Although venereal disease might be transmitted during childbirth or lactation, the most common method was through sexual intercourse. While a female carrier might seem to be "sound", she could have had an ulcer or pustule in the vagina; moreover, according to Sydenham, she did not exhibit symptoms as often as males since the infection was partially drained off through menstruation.[149] Women were considered to be the stealthy carriers of the disease, but it was men who became branded with the shameful disease. The basic treatment for venereal diseases followed a course of difficult physic. Sydenham argued against the common treatments by which patients received bleeding, other evacuations, and a "low diet", as well as the mercury treatment. Sydenham thought that a patient undergoing the mercury treatment needed all of his strength. In minor circumstances, a patient might recover with the use of a less drastic medicine of jalap root.[150] However, since venereal diseases often became externally visible in males, surgery became one treatment option. Indeed, Margaret Pelling asserts that surgeons were the primary practitioners in the treatment of venereal disease since physicians had failed to develop effective remedies.[151] The London surgeon Joseph Binns routinely gave his syphilis patients 'pill Barbarosa' for purging and injected green water in their urethras. He also gave them a diet drink with senna. If the condition persisted, he then prescribed a month of treatment with guaiacum or mercury.[152] Binns treated his patients' symptoms. To him, gonorrhea, or penis discharge and discomfort during urination, itself was a symptom. However, when the apostems of venereal disease appeared, he treated them the same as he would a swelling caused by a wound.[153] As such, surgical intervention might be used. Sydenham recommended that if there were a tumour on a bone, the tumour needed to be treated before using mercury; "the bone must be laid bare by applying a *caustic* to it."[154] Surgery could also be applied to the penis; surgeons had special instruments for injecting medications into the penis and also applied treatments directly onto the penis.[155] One of the primary insults for a man was to imply that he suffered from the pox. A woman might also be accused of being pocky or of visiting surgeons, but the disease left the most obvious signs on men. The frequency of attacks such as "my husband doeth not look like thy husband for my husband's prick was never burnt with the pocke nor halfe of it cut off on Newgate markett as thy husbands was" indicates that surgery for venereal disease was not uncommon.[156] Since the wages of sexual sin were visible on the male body, men's symptoms of venereal disease were more likely to be treated by surgery than women's--and surgery was always a risky undertaking.

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[143] Ibid., n. 5, 131.

[144] Thomas Sydenham, "On Veneral Disease. To the Most Learned and Illustrious Henry Paman, M.D.", 115-128 in Selected Works of Thomas Sydenham, M.D. ed. John Comrie (London: John Bale, Sons and Danielsson, Ltd., 1922), 116.

[145] Margaret Pelling, "Appearance and Reality", 90.

[146] Winifred Schleiner, "Moral Atitudes toward Syphilis and Its Prevention in the Renaissance", 389-410 in Bulletin of the History of Medicine 68 (1994), 395; Anna Foa, trans. Carole Gallucci "The New and the Old: The Spread of Syphilis (1494-1530)", 26-45 in Sex and Gender in Historical Perspective ed. Muir and Ruggiero (Baltimore and London: Johns Hopkins University Press, 1990), 26.

[147] Sydenham, "On Venereal Disease", 117.

[148] Schleiner discusses the 'national' character of syphilis by which the sixteenth-century English writers blamed the Spanish or the French, epitomising everything they hated in "Moral Atitudes toward Syphilis", 391-392.

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[149] Ibid., 118.
[150] Ibid., 121-123.
[151] Pelling, "Appearance and Reality", 101.
[152] Beier, Sufferers and Healers, 88.
[153] Ibid., 64.
[154] Sydenham, "On Venereal Disease", 126.
[155] Pelling, "Appearance and Reality", 102.

The only significant area of surgery for female-related problems was breast cancer, and even then it was performed somewhat reluctantly. In most cases, the best that could be achieved was treatment of the pain. Riverius described how a woman with breast cancer took laudanum every night "and had no hurt, but very great comfort thereby."[157] Nonetheless, surgery was sometimes undertaken. Joseph Binns treated six cases of breast cancer, but only operated twice.[158] On 3 February 1648, he removed Goodwife White's (of St. Giles in the Fields) cancerous breast; she was his only patient who survived her cancer, reported to still be alive in 1653. Binns tried breast surgery seven months later, with "a double ligature upon the woman's breast on the 9 August"; two days later, he tied it harder, and continued to do so until the 22 August. By that time, the lower string was through the length of a finger and the upper almost an inch; he cut off the breast in the ligature. The woman bled freely and died a week later. After this attempt, Binns reverted to cautious treatments of breast cancer, dealing with the tumours and ulcers as he would non-cancerous ones.[159] Although surgery could be advised for the easily accessible breasts, surgery was not recommended for vaginal or uterine cancers.[160] Similarly, while venereal disease was visible on men's bodies, and became subject to surgery, women's concealed apostems and fistulas (both possible indicators of veneral disease) were less likely to be 'cut'. In the case of Elizabeth Pepys' vaginal fistula, for example, other methods of treatment could be found to deal with the problem. Even in the case of prolapsed uteruses, surgery was a last and infrequent resort. A surgeon or midwife would reinsert the uterus and place in a pessary to support the uterus. Bed rest was then advised. In 1659, Willughby, for example, saw a prolapsed uterus "as big as two fists" and, after "put[ting] it up", he inserted a pessary, which then allowed the patient to go about light work.[161] Only when the uterus became ulcerated or gangrened was surgical intervention considered; even so, the extent of surgery, whether a section of vaginal tissue or the uterus itself should be removed, was debated. While Jane Sharp related a historical example of a woman having her uterus removed successfully in 1520, Dionis who wrote in 1719 doubted that a full hysterectomy had ever been performed.[162] Not only was operating on the female genitals more difficult than operating on the males' gentials from a technical perspective, but women's treatments primarily fell under the realm of physicians since the female sexual organs were considered to be internal.

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[156] As quoted by Gowing, "Gender and the Language of Insult", 13. Where illicit sexual activity was inscribed upon the male body through the marks of venereal disease, women's illicit sexual activity became apparent through pregnancy.

[157] As quoted from L. Riverius, The practice of physick (1655) by Eccles, Obstetrics and Gynaecology, 85.

[158] Beier, Sufferers and Healers, 60.

[159] As quoted. Ibid., 82.

[160] Eccles, Obstetrics and Gynaecology, 84.

The differences in surgical intervention and physic as treatments reflects the medical system of the seventeenth-century. Since women's problems occurred within the body, their treatment most often consisted of internal remedies.[163] Practitioners could not see inside of the female body to determine the problem. Although the speculum provided a limited opportunity to see inside the female body, the actual processes and interior of the body remained unknown. Moreover, surgical interference would have led to further complications for something otherwise unseen. Thus, women were likely to be treated according to the standard humoral theories, general courses of physic, and lifestyle recommendations of the day. Unable to see the problem, practitioners could really only treat women according to their symptoms. Men, in contrast, had their genitalia on the outside of their bodies. Treatment of the outside of the body generally fell under the surgeon's expertise.[164] Although less drastic treatments would have been offered initially, surgery remained as the extreme, but not necessarily infrequent, option. Thus, the medical treatments offered to women were not as bleak as misogynistic medical theories would have suggested. Even allowing for the personal attitudes of the medical practitioner and his personal modifications of the theories, the treatment of women's problems occurred within the broader medical theories and practice. Indeed, if one wishes to look for 'harsh' treatments, male problems with their greater likelihood of surgical intervention[165] placed men at a slight disadvantage when it came to brutal treatments.

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[161] As quoted in Eccles, Obstetrics and Gynaecology, 80-81.
[162] Ibid., 81.
[163] Eccles notes that for 'women's problems' that operative treatments were used primarily for breast cancer; other ailments, including cancer, were predominantly treated with physic, plasters, and injections. Ibid., 84.
[164] Wear, "Early Modern Europe", 293-295.

When women became patients, they did not become passive in their own medical treatment. Not only did a woman select practitioners according to her own needs, but she maintained financial control and determined the limits within the patient-practitioner relationship. The adoption of a sick role, moreover, allowed women the opportunity to gain or regain power over their families and their own lives. Finally, even when a woman gave herself into the hands of a practitioner, her medical treatment was not affected by the widespread beliefs in women's inferiority. In fact, women's roles as patients demonstrate both that seventeenth-century English women exerted significant control over their own health care and that sickness, conversely, offered women the opportunity to control their own bodies.

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[165] Other male problems such as 'the stone' or hernia were also treated with surgery.

Conclusion

I began this thesis by asking whether or not the encroachment of a male-predominated profession and a misogynistic medical theory affected the health care received by women. Implicit in this question are issues of women's knowledge and power over their own bodies within a patriarchal society. The assumption that women were losing control of their health care during the seventeenth century and were directly affected by the increasingly misogynistic theories is a simple one to make. However, a closer investigation of the subject indicates that women were not powerless and, in reality, maintained a high level of control over their bodies through their knowledge and health care.

An important beginning point for this discussion was a comparison of the perceptions of women's bodies held by scholars, popular culture and women themselves. The understanding of the female body was central to all academic debate and concepts about women's health. Within scholarly medicine, the ideas about women's passivity, inferiority and weakness increasingly added support to the patriarchal culture. Yet, these ideas contrasted sharply with the 'powerful' female body of popular culture which co-existed; although this power was negative, the culture did not see women as weak or inferior, but powerful enough to be feared. Nonetheless, as magical beliefs declined, the power attributed to women's bodies decreased. According to both scholarly and popular culture, women were increasingly perceived as passive. Yet, women's ideas about their own bodies both diverged from and paralleled these ideas. Women, like the broader society, had a love-hate relationship with the female body. For example, most women agreed that they were physically weak and prone to illness and that motherhood was their God-given role. However, women could also subvert stereotypes about women's bodies to their own advantage, as in the case of miscarriage and inducing menses or abortions. Indeed, ideas about the female body were not clear cut for scholars, popular culture, or women. Just as the early modern body was considered to have permeable boundaries with the outer world, ideas flowed easily between the three groups. While women may have 'bought into' misogynistic concepts, popular culture and women's beliefs modified the misogyny of 'elite' practitioners.

This understanding of the female body formed the basis for women's medical knowledge. Women were medical experts for two reasons: they provided medical care to their families and, as a result of their reproductive and childbearing disorders, they required more frequent medical care throughout their lives. Moreover, the importance of medical knowledge to women can be seen in the existence of a "collective culture of women". Through these female networks, women transmitted knowledge about medicine in general and female subjects, such as pregnancy, miscarriage, and abortion. The informally gained medical knowledge of women was also extensive, often equivalent to that held by formally trained practitioners. Medical practitioners, like Dr. John Symcotts and John Locke, recognised the expertise of women. Both practitioners wrote down medical recipes given to them by women. Little exploration has been done on what women's medical knowledge was, but domestic guidebooks are one source that reveals what knowledge was available to women and reflects the understanding of oral culture. The medical knowledge contained in the guidebooks closely paralleled the medical knowledge of midwifery manuals and Dr. John Symcotts' casebook. Women had access to a high level of medical knowledge and were recognised for their expertise within society. In having such knowledge, women were not only capable of treating themselves, but of determining their own treatments even when under the care of a medical practitioner.

Even as patients, women continued to retain control of their health care. Women chose their own practitioners and determined the limits of their medical treatments, if not the treatments themselves. The patient-practitioner relationship was governed by economics and trust. Having economic control ensured that if the patient did not like the care that she received, she could find another practitioner. Trust, moreover, meant that the patient required the practitioner to listen to and be sympathetic toward her needs. When a patient surrendered control over her body, she gave the control to someone in whom she had confidence. These aspects of the patient-practitioner relationship can be seen most clearly in the childbirth process; although the expecting mother became subject to her gossips and midwife, she had deliberately chosen people whom she trusted to be extensions of herself. Furthermore, when a woman received medical treatment from practitioner, the treatments did not reflect in practice the growing misogyny of the medical theories. The majority of treatments for women's diseases followed the basic course of physic. In contrast, men were disadvantaged in medical treatments because their diseases were more likely to be treated with surgery. Another way in which the sick role could be a powerful one was through a woman's determination of the point at which she adopted the sick role. To some extent, women could regain power over their bodies through the manipulation of their patienthood. The process of becoming a patient entailed the woman becoming the centre of attention and caused disruption within the household as the rest of the family took on her normal tasks. The sick role also offered women, such as Elizabeth Pepys and Lady Brilliana Harley, the opportunity to give direction to their lives. Similarly, during the lying-in month after childbirth, women regained control over their bodies, subject neither to the growing foetus nor to the demands of their husbands. Even the allegedly 'passive' role of patient allowed women significant opportunities to decide her own health care.

Several questions for further investigation emerge from this thesis. One overall area which requires further study is the relationship between patriarchy and medicine; omitting the political issue of patriarchy overlooks a potentially important area of investigation--that of the power relationship between men and women.[1] As this thesis has demonstrated, the relationship between women and the patriarchy of society was central to medicine; medical theories supported patriarchy, but women in turn undermined patriarchy. More specifically, in Chapter One, the tendency of women's historians to concentrate on women's reproductive and sexual roles is seen to be justified. Seventeenth-century women defined their bodies by their reproductive and sexual roles, thought that they were more sickly than men because of their female bodies, and perceived child-bearing in terms of illness. However, new questions need to be asked. Instead of concentrating on what men thought, what was the meaning of the female body, reproduction, and sexuality to women? Moreover, a further comparison between the views of scholars, popular culture, and women should be undertaken. The transmission of ideas between these groups was more fluid than often considered. Other areas for future exploration arise in Chapter Two. The source of women's medical expertise has been overlooked. Domestic guides, a source for women's history which has not been examined in any detail, offer one source for examining the knowledge available to women. Indeed, further investigation into the content of the guides, the audience and their methods of reading might prove valuable for the histories of medicine and women. Using domestic guides as a source for the interface between written and oral culture could also offer an opportunity to examine the knowledge of 'lower' classes, otherwise inaccessible to historians. Finally, Chapter Three brings up the necessity of exploring the significance of gender in medicine. For example, did sickness have different meanings to women than to men and did other medical treatments have a gender bias?[2] There also needs to be more exploration into how women might have subverted the sick role within the patriarchal early modern society to gain power.[3] The study of early modern women's health care is a wide field with potential for continuous growth.

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[1] Judith Bennett, "Feminism and History", 251-272 in Gender and History 1, 3 (1989), 258-259.

Within this thesis, a complex picture of women's health care has emerged. It is not as simple as arguing that women were victims to harsh medical treatments and practitioners who had been indoctrinated by misogynistic theories or that medical theory automatically became medical reality. The theories certainly bolstered the patriarchy of the society, but seventeenth-century English women had ways of subverting that patriarchy. Since medical knowledge and treatment equalled control over bodies, it is important to question who held that control. Women had their own understanding of the female body and their own medical knowledge, ensuring that they could treat themselves or make 'informed' decisions about their treatment. When women became patients, choices remained open to them; due to the strength of economic sway in the patient-practitioner relationship, practitioners were bound to provide good 'customer service' as defined by the patient. When a patient chose to relinquish control of her body, she did so to someone she had selected. The sick role, moreover, was a potentially powerful one for women. Women could manipulate common ideas, such as miscarriage, to their benefit; likewise, the patient gained power by becoming the centre of attention. Lastly, medical treatments did not reflect the growing misogyny. Since practitioners were men of their culture, as well as their training, their ideas were modified by the reality of their society and by the demands of their patients. Indeed, despite the medical theories, the medical treatments did not have an inherent bias against women, but merely continued along the common methods of treatment. During the seventeenth century, women retained more power over their own health care, and consequently over their bodies, than has been considered by modern historians. The list of medical duties toward one's family that Gervase Markham outlined for women was a lengthy and important one; women were to have knowledge of physic, administering treatment, preventing sickness, and curing the sickness when it occurred. Ultimately, this knowledge ensured that women determined their own health care. Although male practitioners dictated women's health care through theory at the same time as they establised the weakness of women's bodies and natures, the reality was different. Women held the power to identify and name their own sicknesses and cures, and consequently, to control their own bodies.

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[2] For the nineteenth century, Mark Micale has studied the subject of male hysteria and the implications for gender in "Charcot and the Idea of Hysteria in the Male: Gender, Mental Science, and Medical Diagnosis in Late Nineteenth-Century France", Medical History 34 (1990): 363-411.

[3] This has been examined for later periods. Cf. Ehrenreich and English, For Her Own Good.

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